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AMERICAN INSTITUTE OF HOMŒOPATHY

TRANSACTIONS

OF THE

FIFTY-EIGHTH SESSION

HELD AT

CLEVELAND, OHIO, JUNE 17-21, 1902

EDITED BY

CH. GATCHELL, M.D., GENERAL SECRETARY

CHICAGO
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1902

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REGULAR PHYSICIAN.—A GRADUATE OF A REGULARLY INCORPORATED MEDICAL COLLEGE. THE TERM ALSO APPLIES TO A PERSON PRACTISING THE HEALING ART IN ACCORDANCE WITH THE LAWS OF THE COUNTRY IN WHICH HE RESIDES.

PRESIDENT JOHN W. DOWLING, M.D.

(SEE TRANSACTIONS OF 1881, PP. 33, 68 AND 71)

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(SEE TRANSACTIONS OF 1899, PP. 57, 102)

IN JUNE, 1881, AND IN JUNE, 1899, RESPECTIVELY, THESE DEFINITIONS WERE ORDERED PUBLISHED CONSPICUOUSLY IN THE TRANSACTIONS EACH YEAR

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NOTE

In preparing this volume of TRANSACTIONS promptness and accuracy have been sought. The trust is expressed that both objects have been attained.

The Secretary has received a number of requests for copies of the Institute's code of medical ethics. In order to respond to this demand it has been included in the present volume.

It is right to explain that the Necrologist, with the promptness and care which characterizes his every effort, early placed in the hands of the Secretary his official report, consisting of sketches of the lives of members deceased. Soon after this was done the manuscript was, by accident, destroyed. In order to relieve the Necrologist of the labor of reproducing the report—too much to ask of any busy man—the Secretary, in justice, undertook the task himself. In carrying it out he called upon others for assistance. All to whom he applied very kindly responded. It is for this reason that several of the notices will be found to have attached to them the names of those who, otherwise, would not have taken part.

CH. GATCHELL, M. D.
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CHICAGO, SEPTEMBER 15, 1902
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EUGENE B. NASH, M. D. (4 yrs.).....Courtland, N. Y.
MATILDA J. LYONS, M. D. (5 yrs.).....Cadiz, O.

BUREAUS
1903

Materia Medica and General Therapeutics

GEORGE ROYAL, M. D., *Chairman*.....505 Walnut Street, Des Moines, Ia.
J. HERBERT MOORE, M. D., *Secretary*.....1329 Beacon Street, Brookline, Mass.

Clinical Medicine and Pathology

JNO. W. DOWLING, M. D., *Chairman*.....116 W. 48th Street, New York.
WALTER SANDS MILLS, M. D., *Secretary* ...154 W. 119th Street, New York.
A. P. WILLIAMSON, M. D.....Minneapolis, Minn.
D. M. GIBSON, M. D.....St. Louis.
J. P. RAND, M. D.....Monson, Mass.
FRED B. PERCY, M. D.....Brookline, Mass.
CHAS. L. NICHOLS, M. D.....Worcester, Mass.
C. E. TENNANT, M. D.....Denver, Colo.
CLARENCE BARTLETT, M. D.....Philadelphia.
H. V. HALBERT, M. D.....Chicago.
W. B. HINSDALE, M. D.....Ann Arbor.
GEO. R. SOUTHWICK, M. D.....Boston.
B. R. JOHNSTON, M. D.....Brooklyn.

Homœopathy

THEO. Y. KINNE, M. D., *Chairman*.....9 Church Street, Paterson, N. J.
W. A. DEWEY, M. D., *Secretary*.....Ann Arbor.
PEMBERTON DUDLEY, M. D.....Philadelphia.
CH. GATCHELL, M. D.....Chicago.
H. C. ALLEN, M. D.....Chicago.

Sanitary Science and Public Health

JNO. P. SUTHERLAND, M. D., *Chairman*.....295 Commonwealth Ave., Boston.
JNO. A. ROCKWELL, JR., M. D., *Secretary*.....3 Worcester Square, Boston.

Pedology

ANNIE WHITNEY SPENCER, M. D., *Chairman*.....Batavia, Ill.
FRED W. WOOD, M. D., *Secretary*.....3901 Cottage Grove Avenue, Chicago.

NOTE—The full membership of the Bureaus for the Session of 1903 will be made up by the several Chairmen at a later date.

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AMERICAN INSTITUTE OF HOMŒOPATHY

TRANSACTIONS

OF THE

FIFTY-EIGHTH SESSION

CLEVELAND, OHIO, JUNE 17-21, 1902

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AMERICAN INSTITUTE OF HOMŒOPATHY

FIFTY-EIGHTH SESSION

CLEVELAND, OHIO, JUNE 17, 1902

FIRST DAY

The Fifty-eighth Annual Session of the American Institute of Homœopathy was called to order by President James C. Wood, M. D., of Cleveland, Ohio, at 4 o'clock p. m., in the Auditorium of the Chamber of Commerce Building.

In opening the meeting the President made the following preliminary address:

LADIES AND GENTLEMEN:—It is my privilege and my pleasure to announce the opening of the Fifty-eighth Annual Session of the American Institute of Homœopathy.

The radical changes recommended by the Committee on Revision of the Constitution and By-laws makes it unwise for me, as your presiding officer, to present for your consideration at this time specific recommendations. That Committee comes to you with a majority and a minority report. In order to show the exact effect which these reports will have if adopted, I have had the proposed changes printed in full, so that you may be able to deal with them deliberately and intelligently. It is evident to all who have given serious thought to the subject that we have come to a parting of the ways. We have outgrown the plan under which we are working at the present time, and unless we meet the emergency which confronts us, the Institute will be depleted by the special societies which have sprung from the parent organization because of the conditions which prevail. That there is a wide difference of opinion as to the best way of correcting these conditions is shown by the two reports which your Committee has presented. I sincerely hope that all who have the best interests of the Institute at heart will aid us with their presence and their votes in deciding this most important subject.

In my annual address this evening, at which time I shall formally express my appreciation for the high honor conferred upon me by making me your presiding officer, I shall consider the present status of homœopathy and its relation to the dominant school of medicine. Never has there been a time in the history of our school when the crisis was greater than it is at the present time. The subject is one demanding fearless discussion and unwavering action. It is, however, one which can best be handled in a general way, rather than specifically. The atmosphere of the entire civilized world is pregnant with liberal expressions. Long-existing barriers, which for centuries have circum-

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scribed freedom of action and stifled progress, are being razed to the ground by intellectual batteries of the twentieth century. Personally, I believe that the homœopathic school has kept pace with the emancipation of human thought which was inaugurated during the last years of the century closed. We shall pass through the crisis and come out of it the stronger if we but heed the signs of the times and take our bearings anew. The conditions do not, in my opinion, call for any surrender of principle, but rather a restatement of facts. That I have failed to cover the ground in an entirely complete and satisfactory way is evident to no one more than to myself.

A glance at the official programme will show you that if we are to complete the work therein outlined, promptness is absolutely imperative. I shall therefore have to exercise my full prerogative as presiding officer and keep you strictly within bounds as regards time. In the business sessions I shall endeavor to be on time to the minute, and I sincerely hope that the convention will not leave the many important matters to be considered during these sessions to the few faithful members who shirk neither responsibility nor work.

I desire at this time to express my thanks to the various officers of the Institute who have ever been ready to aid me in counsel and advice; to the several bureau chairmen who have promptly responded to all of my appeals; and to the heads of the various committees who have cooperated with me in every possible way to make the present meeting a most successful one. I beg your consideration and indulgence in the many errors which I shall commit while presiding over your deliberations.

THE VICE-PRESIDENT, DR. EDWARD BEECHER HOOKER: I will appoint as the Committee on the President's address, which is to be delivered this evening, Dr. James W. Ward, of San Francisco, California, Dr. O. S. Runnels, of Indianapolis, Indiana, and Dr. Howard P. Bellows, of Boston, Mass.

DR. T. FRANKLIN SMITH: It seems to me, Mr. President, that before we commence the regular business of the Institute it is right and proper that we should pause and offer a tribute of affection to the memory of one whom we loved, one who has occupied the highest position in the gift of the Institute, an ex-President, and one who for many years has been a member of the Senate of Seniors, who, on Sunday last, passed to the Great Beyond, and whose funeral services are probably at this very moment being conducted. I move that the Secretary be instructed to send a message on behalf of the Institute to the widow of our late companion, Selden H. Talcott, M. D., expressive of our sympathy and our condolence with her in her severe bereavement.

DR. CHESTER G. HIGBEE: I second the motion.

THE PRESIDENT: The motion is seconded. It is very timely and appropriate. I think no discussion is required. As many as are in favor of this motion will signify it by rising. The motion is carried unanimously and the Secretary is instructed to send such a telegram

THE PRESIDENT: The next is the report of the Executive Committee, Dr. Charles Gatchell, Secretary.

THE SECRETARY: The Executive Committee respectfully reports that it held a meeting February 9, 1902, in this city, with four mem-

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bers present. The principal business transacted was the selection of the city of Cleveland, Ohio, and the days June 17 to 21, as the place and the time for holding the Fifty-eighth session of the Institute. Other business was such as is prescribed by the by-laws. It resulted in the preparation of a printed schedule and program, which is herewith presented. The Committee asks that it be accepted as part of its report. The Committee also respectfully recommends that the printed program be adopted as the order of business for this session of the Institute.

THE PRESIDENT: Gentlemen, you have heard the report of the Executive Committee, made through the Secretary. What will you do with the report?

DR. BUSHROD W. JAMES: I move that the report be accepted, and that the order of business recommended be made the regular order of business.

The motion was seconded and carried.

THE PRESIDENT: Report of the Committee on Publication, Dr. T. Y. Kinne.

DR. T. Y. KINNE, Chairman, read the following report:

THE PRESIDENT AND MEMBERS OF THE AMERICAN INSTITUTE OF HOMOEOPATHY:—Your Committee on Publication, with pleasure report that last year's Transactions are out in time for this year's meeting. The labor of the committee has not been arduous, for the reason that the number of papers being fewer, there was but little need of elimination. We think the plan adopted by the Institute, and by the various Sections, of having fewer papers and more discussions, has worked admirably, and while simplifying the work of the Committee will enhance the value of the Transactions.

Excuses for delay are not in order; but, possibly, reasons may be given which will, in a measure, account for tardy delivery of the book.

First—The strike of the Printers' Union in New York just after the contract was given out, caused unavoidable delay.

Second—Two persons having charge of the work produced some confusion, delay, much proof-reading and a little friction.

Third—The rule of the Institute permitting speakers to revise their remarks, oftentimes adding much thereto, was another source of annoyance.

We think economy of work, lessening of time and increase of satisfaction could be attained by the following recommendations, which we respectfully make:

First—That no participant in the discussion before the Institute, or Sections, be permitted to revise his work subsequent to the adjournment of the Institute; or, in other words, to eliminate from Article III., Section 5, the authority there given.

Second—That one person shall have sole custody of, and be responsible for all matter included in the Transactions. As the work is now arranged it is a moral impossibility to issue the book within the time limit ordered by the Institute.

THEO. Y. KINNE, *Chairman.*

THE PRESIDENT: The report is received. What will you do with it?

DR. BUSHROD W. JAMES moved, and it was seconded, that the report

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be accepted and referred to the Committee on Revision of the Constitution and By-Laws. The motion was carried.

THE PRESIDENT: The next is the report of the Treasurer, Dr. T. Franklin Smith.

THE TREASURER then read his report, as follows:

New York, June 10th, 1902

American Institute of Homœopathy, in account with Thomas Franklin Smith, Treas.

Receipts.		
Balance from old account	$ 325.65	
By cash received from dues and initiation fees	7,101.00	
" " " " interest on deposits	8.73	$7,435.38
Disbursements.		
To cash paid Committee on National Medical Legislaton	$ 10.00	
" " " Press Committee	13.55	
" " " Committee on Drug Provings	300.00	
" " " Committee on Organization, Registration and Statistics	337.94	
" " " Expenses of Treasurer to Richfield Springs	93.79	
" " " Sundry Printing	627.02	
" " " Printing Transactions of 1901	3,019.05	
" " " Expressage on Transactions	606.40	
" " " Ames & Rollinson, Certficates	55.83	
" " " Eugene H. Porter, Secretary, salary	1,000.00	
" " " Eugene H. Porter, bill for postage	156.79	
" " " Wilson A. Smith, Recording Secretary, salary etc.	502.85	
" " " Treasurer, bill for postage and sundries	313.14	
" " " Mount Morris Safe Deposit Co., vault	60.00	
Balance to account	339.02	$7,435.38

THOMAS FRANKLIN SMITH, *Treasurer.*

On motion the report of the Treasurer was referred to the Auditing Committee.

THE PRESIDENT: The chair will appoint as the Auditing Committee Dr. J. B. G. Custis, of Washington; Dr. W. H. Hanchett, of Omaha, and Dr. J. P. Cobb, of Chicago. The next is the report of the Committee on Local Arrangements, Dr. G. J. Jones, Chairman. In the absence of Dr. Jones Dr. J. Richey Horner will kindly report.

Dr. Horner announced the arrangements in regard to the times and places for holding various exercises and entertainments during the week, and for committee meetings.

THE PRESIDENT: Report of the Committee on Resolutions, Dr. B. F. Bailey, Chairman.

DR. B. F. BAILEY: Mr. President, the Committee on Resolutions desires to announce that it will hold a meeting immediately after adjournment each day, and any matters to come before it will be considered at that time.

THE PRESIDENT: Report of the Committee on Transportation, Dr. John B. Garrison, Chairman.

DR. J. B. GARRISON: Mr. President, the Committee on Transportation respectfully submits the following report:

REPORT OF COMMITTEE ON TRANSPORTATION.

MR. PRESIDENT:—Early in the year the chairman opened correspondence with Mr. F. C. Donald, Commissioner of the Central Passenger Association, asking for reduced rates for the American Institute of Homœopathy and Allied Societies meeting in Cleveland, O., June 16-

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21, inclusive. The various Associations took up the matter, and one by one reported a concurrence, with the exception of the Transcontinental Passenger Association, which refused to do so. The cause of their refusal was given to be that the volume of Eastern travel was so large at this season of the year that they could not afford to offer reduced rates to our members for the trip. We procured an introduction to the General Eastern Passenger Agent of the "Santa Fe" system, and then brought the argument that the members of this Institute who came to the meeting were not coming on a reduced-rate ticket, but must buy a full-fare ticket, the return being at a reduction, when the cars were returning West comparatively empty, and that, therefore, we might have the special rate without injury to the railroad. This gentleman acknowledged that the argument was sound and the point well taken and at once took the matter up with his people and urged for an adoption of the prevailing rate of a fare-and-one-third for the round trip. The home office, however, claimed that it was then too late to make any change in the matter and the rate was denied. We believe that it may be possible next year to obtain rates from this and all Associations. Certainly the element of personal acquaintance plays quite an important part in the securing of special privileges.

The authorities have this year drawn the lines tightly around the holders of certificates, and have required that the special agent sent by them to *vise* the certificates, shall only do so in the presence of the member. This makes it impossible to *vise* the certificates at leisure and then hand them to the passenger, and if all leave the securing of the *vised* certificates until they are ready to go home much confusion must result. Therefore every certificate should be placed in the hands of the Chairman upon arrival, and then taken from the Special Agent who will be present in his room each day as soon as convenient.

Respectfully presented,

J. B. GARRISON, *Chairman.*

THE PRESIDENT: Report of the Committee on Revision of the Constitution and By-laws, Dr. T. Y. Kinne, Chairman.

DR. T. Y. KINNE: Mr. Chairman, your Committee on Revision of the Constitution and By-laws would respectfully report progress, and move that the detailed report be made a special order for to-morrow morning, immediately following the election of new members.

Motion seconded and carried.

THE PRESIDENT: Report of the Committee on Proposed Change in the Publication of the Transactions, Dr. Charles Mohr, Chairman. Dr. Mohr not being present, the report will be passed until to-morrow.

DR. JOSEPH P. COBB: May I say a word on this report? As Secretary of the Committee I presented to the Institute last year a report which was referred to the Committee on Revision of the Constitution and By-laws. I do not think this Committee has any further report to make, Mr. President.

THE PRESIDENT: If there is no objection the report will be passed until tomorrow. Next, preliminary report of the Inter-state Committee.

DR. W. H. HANCHETT: The Inter-state Committee would submit the following preliminary report:

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During the past year great progress has been made along the lines of Homœopathy. Several new Societies have been formed and much active work has been done. By reason of a large correspondence we find that our school is steadily making progress. On the other hand we find that the Allopathic schools are most courteous to us and making all sorts of kind and coquettish glances toward our camp. We believe that their idea is to kill us with kindness. We suggest to the American Institute of Homœopathy, that she be not killed by kindness. From present appearances it would seem that the lion intended by gentle whisperings to appease the fears of the lamb and eventually swallow it. While the Interstate Committee is not disposed to be quarrelsome, it believes that our work as a homœopathic school of medicine has not yet by any manner of means fulfilled its mission. When the old school are ready to admit the law of similia similibus curantur, we will be willing as a school of medicine to join with them in the agreement that we are all physicians endeavoring to cure the sick, alleviate the sufferings and perpetuate the lives of all human beings. Organization should be our watchword. Among our recommendations to this society would be a plain and simple annunciation of our law of cure, plain, simple and practical literature for free distribution among the people, and a firm and loyal patriotism by our practitioners of medicine to our particular school of medicine. We would also recommend that every homœopathic physician throughout the length and breadth of the land do missionary work for homœopathy not only by careful and conscientious prescribing but by word and precept.

As a matter of truth the victory is ours if we, as a school of medicine take advantage of this grand opportunity now at our door. And as the oldest and most honored national society of the United States of America, I beg of you individually and collectively to stand by the truth. By all that is good and holy, yield not a point to the siren song of our adversaries. We do not maintain or claim that the time may not come when all schools of medicine shall be amalgamated, and when truth shall reign supreme, but we do maintain that with the high standard of medical education which our colleges are now demanding, there is no reason why homœopathy should make any retreat or compromise with the enemy. This is but a preliminary report of the Interstate Committee, which will be followed by a more extensive report at our next assigned period.

W. H. HANCHETT, *Chairman.*

THE PRESIDENT: The preliminary report of the Inter-state Committee is received. Next is the report of the Board of Censors. As the Chairman is not yet ready to report, if there is no objection the Chair will suggest that we pass to the order of new business. There are some important matters that should come before the Institute. Under this head the Chair desires to read a communication received a few days ago from the President of the British Homœopathic Society, Dr. Burford.

The letter related to the family of the late Dr. Richard Hughes.

After reading Dr. Burford's letter the President said:

The Chair will further state that in a private letter from Dr. Burford it appears that the needs of the family are very urgent, indeed. The matter was presented to the Executive Committee in session yes-

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terday morning, but it was deemed impossible to take funds from the treasury of the Institute for this particular purpose. Therefore, it was thought best to bring the matter before the Institute directly, and appeal for personal subscriptions. With this end in view the Chair has selected Dr. James H. McClelland, of Pittsburg, to take charge of the matter. The Chair trusts that all will give it serious consideration.

Dr. Jas. H. McClelland: It has been suggested that I undertake to collect a few subscriptions from the members of the Institute and the members of the Homœopathic profession in the United States. I accept the task, not only because I have the heartiest and pleasantest recollection of Dr. Hughes, but because I believe we would be doing ourselves an honor to adopt the suggestion of the President and proceed with the collection of such a fund. And we ought to do it as a thank-offering in memory of Dr. Hughes. Now, Mr. President, there is no time like the present, and though I propose to extend the collection of this fund far beyond this limited circle, I should be glad to hear of any contributions that may be offered at this moment, if the President will allow me the privilege.

The President: Dr. McClelland, the Chair will be very glad to do so, and also to head the subscription with my contribution.

Dr. McClelland then received a number of subscriptions from members, aggregating the sum of more than seven hundred dollars.

The President: Anything further under the head of new business? Dr. George B. Peck will report for the Board of Censors.

Dr. Peck made a report submitting a list of fifty-three names of applicants for membership in the Institute.

The President: The report of the Board of Censors will be received and take the usual course.

Dr. Bushrod W. James: Mr. President, some of the younger members do not recall when the Quinquennial Congresses were instituted, and how they have been carried on. They began in the Centennial year in Philadelphia, when all the Homœopathic organizations of the world were invited to send delegates. That was a large meeting. At that meeting Dr. Hayward, of Liverpool, and Dr. Richard Hughes, of Brighton, England, were delegates from Great Britain. Dr. Hughes was made the General Secretary of that first meeting, and from time to time he was re-elected the Secretary of these Congresses. He was made finally the Permanent Secretary. Only a few weeks ago he was called to the Great Beyond, and I would like, sir, with your permission, to offer a resolution at this time—an international resolution, if you may so term it—as this body was the organization which practically instituted those Congresses. The resolution that I desire to read is as follows:

Whereas, the American Institute of Homœopathy has learned with great regret of the decease of one of its honorary members, Dr. Richard Hughes, of Brighton, England, the Permanent Secretary of the Quinquenial Congress of Homœopathic Physicians ever since their inauguration in Philadelphia, in the Centennial Year, 1876, and who was also the leading homœopathic physician and writer of Great Britain, therefore,

Resolved, that this society make a special minute of the event, and of Dr. Hughes' usefulness to the profession, and the great loss all mem-

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bers of the homœopathic school of medicine have sustained in his removal from the active scenes of life.

RESOLVED, also, that we extend to the widow and children of Dr. Hughes our deepest sympathy in this hour of trial and in the great bereavement which they have suffered in the loss of our greatly beloved friend and physician, whose labors in the cause of homœopathy were arduous and untiring, whose life was one of strict religious integrity, and who was esteemed at home and abroad for all the good qualities which make a true man and upright and conscientious physician.

RESOLVED, As the Institute honored and esteemed Dr. Hughes during life, so we revere his memory, and hereby express our deep feelings of sorrow at his departure from the scenes of the activities in which he was so deeply engrossed, and of which he was such a brilliant expositor, as well as a true-hearted friend.

I offer this resolution, Mr. President, for the consideration of the Institute.

THE PRESIDENT: According to the by-laws this resolution, with all other resolutions, will have to be referred to the Committee on Resolutions, unless we suspend the by-laws.

On motion of Dr. Theodore Y. Kinne the by-laws were suspended.

DR. EUGENE H. PORTER: I move the adoption of this resolution.

Motion seconded.

THE PRESIDENT: You have heard the motion that this resolution be adopted. I suggest that it be adopted by a rising vote. As many as are in favor of this resolution will please rise. (The members arose.) The vote is unanimous.

DR. GEO. B. PECK, of the Board of Censors, presented six names of applicants, in addition to those already read, making fifty-nine in all to the present time.

THE PRESIDENT: The report of the Board of Censors will be received and take the usual course. If there is nothing further under the head of new business the meeting will stand adjourned until 8 o'clock this evening.

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OPENING EXERCISES

EVENING

The opening exercises of the Fifty-eighth Annual Session of the American Institute of Homœopathy were held in the Chamber of Commerce Auditorium, Tuesday evening, June 17th, 1902.

One of the largest and most distinguished audiences which ever greeted the American Institute at its opening exercises was assembled when the Vice-President, Dr. Edward Beecher Hooker, arose and requested the Very Rev. Charles D. Williams, Dean of Trinity Cathedral, to invoke the divine blessing.

The Rev. Charles D. Williams, D. D., offered prayer.

THE VICE-PRESIDENT: We are indeed fortunate that we are to be welcomed to this beautiful city by its chief executive officer, whose reputation extends beyond the confines of this city and of this State. I have the honor to present to you the Honorable Thomas L. Johnson, the Mayor of Cleveland.

MAYOR JOHNSON: Mr. Chairman, Ladies and Gentlemen: The Chairman was very particular to ask whether my name was Thomas or Tom, and I explained it fully, and then he got it wrong. Unfortunately, or fortunately, my name is only spelled with three letters, Mr. Chairman. Still it is my pleasant duty occasionally to welcome to this city distinguished bodies of men and women from all parts of the United States. There are some unpleasant things connected with the Mayor's office, but I assure you that to perform an office of this kind is always a pleasant one. Generally it is a gathering of men; generally it is men gathered together from some craft in which they, from bad taste or some other cause, leave the ladies out. It has never been my good fortune before to welcome to the city of Cleveland a gathering composed so largely of the fair sex, and I want to say to you that it is an added charm to-night, and I extend to you with an added heartiness a welcome to our city, and wish you every comfort, convenience, and happiness while you are here. So to speak, I turn over the keys of the City to you, and trust that your stay in our midst will be so pleasant that you will carry from your visit here a recollection that will bring with it a desire to come into our midst again.

We are making grand preparations here for a beautiful city. From a village, we have suddenly emerged into a great municipality. Arrangements for a grouping plan that will make it more beautiful and attractive are under way; but I do not know that any reputation will be so much appreciated by the people of Cleveland as to be known all over the United States as a hospitable city; one to which, when people visit us, they care to come again.

My friends, wishing you every happiness while here, and a hearty welcome, allow me again to say "You are very welcome to our gates."

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DR. E. B. HOOKER, VICE-PRESIDENT: It is quite true that His Honor, the Mayor, did tell me a moment or two ago that his name is Tom. I had never met the gentleman before and I confess that I was so impressed by his breadth and dignity that as I presented him to you I tried to fit the name to him rather than to remember exactly what his name is. We will next listen to an address of welcome from the Chairman of the Local Committee of Arrangements, Dr. G. J. Jones.

DR. GAIUS J. JONES: Mr. President, Ladies and Gentlemen, and Officers of the American Institute of Homœopathy. For two long years we have anticipated this pleasure, the pleasure of meeting you in Cleveland. The latch-string has been out, the light has burned in the window for you, the fatted calf has grown fatter until he has become too valuable an animal to sacrifise for any prodigal son or collection of chosen friends. Those of you who have not been here before, wonder how a city of 400,000 inhabitants has grown up so suddenly, how pastures have been changed into parks and boulevards, and dry and sandy hills have been covered with the tallest buildings and most beautiful streets. This can be answered largely in one word—iron.

Before the Civil War, cotton was said to be king of this country, and king it was for many years; but the sceptre has long since passed from Georgia and Mississippi to Wisconsin and Minnesota, and iron now is the ruling monarch of the world. Wherever iron and its associate mineral, coal, can meet, there grows a city; and any Nation that can most successfully combine these two minerals becomes incomparable in peace and invincible in war. According to the reports of the Chamber of Commerce that owns this beautiful building in which we are meeting, of the 100,000 articles that enter into its construction the major part are composed of iron. And still the demand increases. In the '50's every single bar of railroad iron was imported at immense cost. With millions of tons of iron needing only to be placed upon the car for its transferment to its proper manufacture, with millions more of tons of coal almost cropping out of the surface of the ground, our men were starving in the streets for need of employment, while we paid this tribute to the labor of Great Britain. That is changed now. Four hundred thousand tons of iron rails have been contracted for in the United States for the year 1903, with a possible 200,000 more. This is pre-eminently a manufacturing city.

But this is not the principal thing of which we would speak. It was here that coal-oil was first found to any extent; and here it was that the foundation was laid for that most gigantic combination of capital ever known, which, by its example, has changed the industrial matters of the whole earth. Here, too,the arc electric light was discovered, which now illumines the whole world. The arts and sciences were not forgotten in Cleveland, and everything of that nature has flourished as in no other city of its size.

The Medical Profession has long since claimed advancement here, and only fifty years ago two principal schools of medicine had each a college here. It was here that the second Homœopathic College of the United States was founded; and afterward men who had become tired of prescribing according to what some one else had reported had been

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beneficial in certain cases, without any definite rule of conduct in the matter, had found a positive means of prescribing. So the Western College of Homœopathy was founded, and a college has remained ever since that time. With 2,000 alumni scattered broadcast throughout the United States, many of them the founders of other schools in different states, these few men profited in that way. It is a great undertaking for any one to organize a medical school. One of the first questions asked of any one who applies for a charter for an institution of this kind is whether it is for profit or not. The question is always answered: "Not for profit." And this is always true. A medical college with its dispensaries, its hospitals, and the increased advantages for treating the sick, is an institution of which any city can feel proud. This is why we are proud to be called residents of Cleveland, but prouder still to be called citizens of what the late Gen. William Gibson called the United States of Ohio. This portion of Northern Ohio was a garden spot. After the aboriginal inhabitants had failed of proper assimilation, he originated that habit which has clung to the people of this country ever since—of removing his family West. The first who came were the flower of New England, led by John Moses Cleveland, whose name the City bears, and the representation of whose figure stands but a short distance from where I am speaking, staff in hand, rendered apparently speechless on account of the rapid changes coming on to him. Following them came the best of the citizens of the other States and a few from foreign countries. Then there was found the log school-house on almost every principal cross-road. And the literary world has wondered ever since how these people could, in the few months winter's course, sandwich in between the hardest kind of toil, one-quarter the amount of information which they did. Knowing all these facts, it is no wonder to us to believe in the influence of heredity, and more in the influence of education; that whenever an important crisis occurred in the State or in the nation and a leader was wanted, that all eyes instinctively turned toward the Western Reserve.

We have met the American Institute here before. We have heard about this Institution over half a century ago; and in thinking about that I have wondered how this society, organized as it was without any authority of law from any city or nation, should have held sway over the profession for all these years; settling the disputes of colleges, of societies, of individuals, with very little of dissent; and all honor is due to those brave men and women who organized this body; who left their homes at great sacrifice of business and sometimes of health, for the purpose of keeping it up, and doing what they considered their paramount duty to their profession. This extremely democratic body has wielded more influence than almost any judicial tribunal in the land. You met here in 1873, and in looking over the transactions of that year I noticed that the officers of both 1873 and 1874 are included; and it needs but a glance at the roster of the Institute for those two years to prove to us the brevity of human life; of the two presidents, the one, that noble man from Chicago, Small only in name; the talented Hulen of Jersey City; the president of '94, Berger of Pittsburgh, known all over this country; the vice-president of '73, our own Dr. Snider; the vice-president of '74, a man who accomplished more in the short period

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of time which he was allowed to live in this city than any other man who practiced here. Only one of the nine men composing the two boards of censors is present at this meeting or living to-day. The editorial writer known all over the world, McClatchey, was the recording secretary both years; he, also, has passed to the great beyond. Only one of the three men on the auditing committee, and one of the three on the credentials committee remain. These men fought the good fight. They left us a heritage of which we may be proud, and I am reminded of that verse which, though old, is no less appropriate:

Lives of great men oft remind us
  We can make our lives sublime,
And, departing, leave behind us,
  Footprints on the sands of time.

Footprints that perhaps another,
  Wandering o'er life's solemn main,
A forlorn and shipwrecked brother,
  Seeing, shall take heart again.

To have been one of the committee selected to welcome you to this city has been one of the greatest privileges of my life. To welcome such a body of men and women to such a city as Cleveland is indeed an honor; and I now, on account of the physicians whom I represent, on their behalf, welcome you to this city. May your sojourn here be both pleasant and agreeable, and may none but the pleasantest memories ever remain with you in regard to the Fifty-Eighth Session of the American Institute of Homœopathy.

Dr. Edward Beecher Hooker: It will now be our pleasure to listen to two solos on the piano, by Miss Nellie Belle Jones.

Miss Jones delighted the audience with two exquisitely rendered selections. She was presented with a handsome bouquet of American beauty roses, and graciously responded to an *encore*.

Dr. Edward Beecher Hooker then responded to the address of welcome, saying: Mr. Chairman and Mr. Mayor, and to you Ladies and Gentlemen of Cleveland:

The American Institute is a homeless wanderer on the face of the earth. Year by year the month of June finds it once again on the road, its household goods stored away in trunk and bag, as it hopelessly sets out to try a new location or revisit an old one. It is animated by no sectional spirit. It has camped in the shadow of the Rocky Mountains and been uplifted by their silent glories; its heated discussions have been cooled by the refreshing breezes of Atlantic City; it has visited Washington, the warmth of whose climate is only exceeded by that of its hospitality; it has hobnobbed with the American aristocracy at Newport and felt young again in the honeymoon atmosphere of Niagara. And still it wanders. Did I say homeless? No, not homeless—it has scores of homes. Every spot in which it has dwelt is its home, and now, in its fifty-ninth year, after an absence of twenty-nine years, it returns to Cleveland, one of its early and best-remembered homes.

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It is particularly pleasing to me, a son of Connecticut, to reply to words of welcome in new Connecticut. Only a little more than a hundred years ago that little New England state owned all this great Western Reserve. Indeed, it owned a broad strip of territory extending from Narragansett Bay to the Pacific Ocean. As you doubtless know, the Connecticut school fund, which aids in the education of our children, came from the sale of these lands. I find in your directory a host of old New England names, such as: Wood, Andrews, Everett, Barnett, Cowles, Hale, Ludlow, Olney, Sherwin, Lamson, Williamson, Harkness, Severance, Stone, Brush, Warner, Hayden, Wade, Bishop, Harmon, Babcock, and Johnson. While many of the persons who bear these names are doubtless prominent among your citizens, others may be found in the humbler walks of life, but of the same good old New England stock.

When the hardy and courageous pioneers, who founded this great city, travelled from the east their progress was slow and difficult. As I was speeding across the territory, the other night, through which they made their toilsome journey, accomplishing in fifteen hours what must have taken them six or seven weeks, surrounded by luxury instead of hardship, I was impressed anew not only with the tremendous changes which have occurred in the last hundred years, but also with the indomitable spirit and pluck with which these pilgrims were animated. Of the same stock as those earlier pilgrims, who crossed the seas in search of liberty and to build new homes, your founders had the same energy and determination. Would that we, in these days of softness and of prosperity, had more of their spirit, for there are battles for us to fight and problems for us to solve greater even than those they encountered. We have subdued the wilderness and the savage, and out of many weak States evolved one great, powerful State, our beloved Nation, now occupying a leading place in the World's family of Nations, shirking no just responsibility and seeking no unjust advantage. Yet are we in danger, and the Nation needs more than ever the wisdom and devotion of her patriotic sons and daughters. We are in danger of forgetting, in these days of material prosperity, that true greatness is impossible without righteousness. No matter what the size of their armies and navies, no matter what their manufactures, their mining, their agriculture, a people who cannot rule themselves are in danger. A loss of ideals, a deadening of conscience, are more to be dreaded in a man and in a nation than great disaster.

There was a time, not so long ago, when the fringe of States along the Atlantic sea-board determined the policy of this country. Their influence was paramount, not only in national affairs, but in industrial, social and educational life as well. Their responsibility was great, and history will tell whether or not they wrought worthily. That day has passed. The influence of the Eastern States is yet very potent—and may it long so remain—but it is not paramount. Upon you of the great Middle West has descended the burden of the responsibility once held by the older States, who have sent their energetic, brainy children to build you up. And I believe you are worthy to bear it! You are not trammeled by the conservatism and over-caution of age, nor are you swayed by the recklessness of youth; you are in the ripe maturity of your powers and your dominating influence will largely control the destiny of this coun-

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try. May you have the clear vision, the wide comprehension, the love of righteousness, which will enable you to protect the nation from dangers from without and perils from within.

Among the most difficult problems we have to face is that of municipal government. If democracy has anywhere shown weakness it is in the management of large cities. We have heard of the greatness of Cleveland, of her immense shipbuilding industries, of her astounding lake trade, of her lumber-mills and yards, of her iron and steel manufactories, of her bridge construction, of her railroad system, of her banks, of her splendid parks, her libraries and her institutions of learning. Some of these things we shall see for ourselves, and you may be sure we shall go about with eyes and ears open, eager to learn and not unwilling in friendly spirit to criticize. The greatness of a city is not measured alone by its wealth, its population, or its industries. What progress have you made in adjusting the relations of labor and capital? Is justice meted out to rich and poor alike in your courts? Are your municipal affairs ably and honestly managed? What are you doing to elevate humanity? I believe that the answer to these questions will also demonstrate that you are a great city, that you are making progress in the solution of social, industrial, municipal and spiritual problems, which will make your reputaton most enviable and that other cities, striving to lift themselves up into higher municipal life, will turn gratefully to Cleveland and take her as their model.

And now, gentlemen, in the name of the American Institute of Homœopathy, I thank you for your gracious words of welcome and for the warm-hearted hospitality that you extend to us. I have, however, one fear, and that is, that we shall become so enamored with Cleveland and its people that we shall all desert our homes and flock to this beautiful city, which would be alike disastrous to the suffering patients we left behind and the suffering physicians here, whose patients would soon become ours.

It is fitting that the American Institute of Homœopathy should dwell here awhile, in a city famed for its medical schools, its hospitals and the high standard of its medical profession. We come in no sectarian spirit, and we offer the right hand of fellowship to every member of the profession and invite him to come to our meetings. All we ask is that the hand that grasps ours shall be a clean one, and that it join ours to uphold the honor and dignity of the noble profession to which we belong.

At the conclusion of his response, Dr. Hooker said:

I now have the keen pleasure of presenting to you the distinguished gentleman to whom you gave the highest office within your power a year ago, Dr. James C. Wood, President of the American Institute of Homœopathy.

Dr. Wood arose and said:

Mr. Chairman, Members of the American Institute of Homoeopathy, Ladies and Gentlemen:

It is with pleasure and with pride that I join with the eloquent speakers to whom you have just listened, in welcoming you to the city

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of Cleveland. I deem it an especial privilege to preside over your deliberations in my home city, whose hospitality has been made famous by the cordial reception which it has ever given to men of science and letters; whose schools and colleges have produced a citizenship second to none other in refinement and education; whose geographical location and enterprise have made it the seventh in population in the United States; whose beautiful avenues, parks and palatial homes are the pride, not only of its residents, but of the entire commonwealth; and whose catholicity of spirit toward the so-called new school of medicine has made it one of the strongest homœopathic cities in the world. I thank you most sincerely for the honor conferred in elevating me to the Presidency of this the oldest national medical organization in the United States and for the privilege of presiding over your fifty-eighth annual session. Were it not for the consciousness of your cordial support and co-operation, I should have greater apprehension as regards my fitness for the high office of president. Again I thank you.

THE PRESENT STATUS OF HOMŒOPATHY.

The American Institute of Homœopathy convenes to-night, June 17, 1902, under very different conditions from those which confronted it fifty-seven years ago at the first meeting. Then it was an infant in swaddling clothes with a membership of but forty; now it is a giant with a membership of over two thousand. Then there were less than three hundred homœopathic physicians in the United States; now there are over fifteen thousand. Then there were no homœopathic colleges and no hospitals; now there are twenty colleges and three hundred and forty hospitals, dispensaries and sanitariums under homœopathic control, having properties and endowments aggregating several millions of dollars. Then there were but two journals devoted to the interest of homœopathy and homœopathic therapeutics; now there are thirty-two. Then the literature of homœopathy was limited to a few books devoted to materia medica and therapeutics alone; now the whole domain of medicine has been covered by writers who practice and teach the law of similars. Then for a member of the so-called regular school to consult with a member of the so-called homœopathic school, meant professional ostracism and disgrace; now such consultations are of daily occurrence and are openly advocated by men occupying high positions in the American Medical Association. Then, and up to five years ago, no credit was given by colleges under the control of the older school for time spent in homœopathic colleges; now students in homœopathic colleges, and homœopathic graduates, are placed on a par in nearly all colleges of the older school with students of, and graduates from, so-called regular institutions. In short, the world has been moving in matters medical as well as in matters religious and political, and he who ignores this fact is either purblind or a laggard. Persecution on the part of the dominant school was followed by tolerance, tolerance has been followed by respect; and respect, unless we guard carefully our vantage ground, will prove but the forerunner of assimilation.

I am prompted, this evening, to indulge in the foregoing retrospection and prognostication for the purpose of bringing the issue which so much concerns the school homœopathic fairly and squarely before

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you. I cannot better define and emphasize the present attitute of the dominant school towards the homœopathic than by quoting from Dr. Reed's presidential address last year, before the American Medical Association. In describing the "New School of Medicine" (Dr. Reed does not mean by this term the "homœopathic" school, but rather the new school of thought), he says: "It acknowledges no distinctive title, it heralds no shibboleth. It is a school of human tolerance, of personal independence, of scientific honesty. It is the slave of neither prejudice nor preconception, and abandons the accepted truth of yesterday, if it be only the demonstrated error of to-day. It places no premium upon personal prerogative, and extends no recognition to individual authority. It makes no proclamation of completeness, no pretension to sufficiency. It recognizes that truth is undergoing progressive revelation, not ending to-day, but continued through the ages. It yields its plaudits to achievement, and recognizes that he is the greatest among men who reveals the most of truth unto men. It greets as a friend him who thinks, though he think error, for, thinking, he may think truth and thereby add to the common fund. It heeds all things, examines all things, judges all things."

Again, Dr. Wm. Osler, of Johns Hopkins University, in the New York Sun, of January 27, 1901, said: "The century has witnessed a revolution in the treatment of diseases and the growth of a new school of medicine. * * * A new school of practitioners has arisen which cares nothing for homœopathy, and less for so-called allopathy. It seeks to study rationally and scientifically the action of drugs, old and new."

Many similar quotations could be made from the writings of prominent men of the dominant school, but the two distinguished gentlemen whom I have quoted represent a type of thinkers that school which is constantly increasing in numbers. On the other hand, a similar type of thinkers is growing up in the homœopathic school, and in many articles upon the present status of homœopathy, and its relations to other systems of therapeutics, these thinkers have shown a disposition to meet their old time antagonists more than half way. In view to these facts I am prompted to-night to propound the following questions, and to answer them to the best of my ability:

1. What influence has homœopathy had, if any, upon the medical thought and practice of to-day as represented by the dominant school of medicine?

2. Has homœopathy fulfilled its mission, and should we now permit ourselves to become a part of the dominant school of medicine?

3. What evidence can we put forth going to show that the law of similars, upon which the homœopathic school is based, is a law of nature and a law of cure worthy of being elaborated and studied by all who have at heart the best interests of humanity?

4. What have been the chief obstacles to the growth of homœopathy and to its acceptance by the dominant school of medicine?

5. Is homœopathy losing in numbers, prestige and popularity, as claimed by certain writers of the dominant school?

6. What should be our attitude toward that school and toward innovations in medicine?

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These I submit are vital questions and should be met fearlessly and without equivocation. As true scientists and sincere humanitarians, we should be willing to cast aside theories which time and experience have proved untenable, and supplant them by others which seem more reasonable and seem also better to conform to modern thought and attested facts. I shall, therefore, undertake to answer them in the spirit of one who cares for schools of medicine as such, the homœopathic not excepted, only so far as he believes that the art of healing can best be subserved by maintaining, for the present, at least, distinct organization.

I begin then by asking: "What influence, if any, has homœopathy had upon the medical thought and practice of to-day as represented by the dominant school of medicine?"

I quote a few extracts from Holmes' *Principia Medicinae,* which was a standard work in medicine one hundred years ago when Hahnemann began his studies. For inflammatory fevers, venesection is advised "until the pulse returns to its proper strength." For ophthalmia, "bleeding, especially from the jugular veins; cupping on the nape of the neck; leeches to the temples and below the eyes, frequently repeated; blisters applied to the neck, behind the ears, on the head and temples; setons and issues in obstinate cases." For pneumonia, "large and repeated blood-letting; when the strength does not admit of further venesection, cupping should be performed betwixt the shoulders; clysters, blisters, large doses of tartar emetic, etc." For toothache, "venesection, mercurial purgatives, sudorifics, emetics, scarifying the gums, leeches to the gums, blisters behind the ears, etc."

This much merely to show that down to the time of Hahnemann twenty-four hundred years of empiricism had done little to dignify medicine as a science, or even to elevate it to the standard of an art. For hundreds, nay thousands, of years talented men had been engaged in the cultivation of the profession of physic. They toiled amidst discouragements and dangers, and exercised a philanthropy and a devotedness for which our meed of praise is offered with an ungrudging hand. But the inference that such efforts did more than blaze the way for that which was to follow, cannot be admitted.

In 1813 Pinel, one of the most celebrated of continental writers, said of the therapeutics of his day: "The materia medica has been nothing but a confused heap of incongruous substances, possessing, for the most part, a doubtful efficacy, and nothing, perhaps, is more just than the reproach which has been attached to it, that it presents only a shapeless assemblage of incoherent ideas and of puerile, or, at least, of illusory observations."

Fifty years later Dr. Paris, the President of the Royal College of Physicians, wrote: "The revolutions and vicissitudes which remedies have undergone, in medical, as well as popular opinion, from the ignorance of some ages, the learning of others, afford an ample subject for philosophical reflection." "And," he says, "passing to modern times, we should not be surprised at the very imperfect state of the materia medica as far as it depends upon what is *commonly called* experience. Ray attempted to enumerate the virtues of plants from *experience,* and the system serves only to commemorate his failures;

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Vogel likewise professed to assign to substances those powers which had been learned from accumulated experience; and he speaks of roasted toad as a specific for the pains of gout, and asserts that a person may secure himself for a whole year from angina by eating a roasted swallow."

Polypharmacy was carried to such an extent that some of the most popular prescriptions, during the seventeenth and eighteenth centuries, contained from fifty to one hundred ingredients.

It was Hahnemann who first brought order out of chaos and placed therapeutics on a scientific basis. He it was who advocated the systematic proving of drugs upon the healthy, the single remedy, and the minimum curative dose. As is well known, he also enunciated the law of similars as expressed in the formula, *similia similibus curentur.* While the law of similars was suggested by writers before the Christian Era, and later had been revised by Boulduc Thoury, Von Störck and especially by Stahl; and while both Haller and Von Störck emphasized the importance of first trying upon the human body the remedy unmixed with any foreign substance, no one of these men had actually made such provings in a systematic way. This painful path was first trodden by Samuel Hahnemann. How greatly his pioneer labors have influenced the older school we can easily determine by examining their literature. Their materia medicas are now filled with the provings of drugs upon the well. Their pages contain innumerable illustrations of the application of the law of similars; and the advantage of administering remedies separately, "in order (in the language of one of the most recent writers) to more accurately observe their effects, as well as to discontinue, or change the dose of, any one which may be necessary," is pointed out by all. Their improved and more refined pharmacology was made imperative by homœopathy.

Much more might be said going to show the influence which Hahnemann and his teachings have had upon modern medical thought; but, inasmuch as the facts which I have put forth are attested by men like Fletcher, Mott, Forbes, Liston, Trousseau and Bristowe of the older school, it seems necessary to adduce no further evidence under this head. Let me say, however, before passing to my next topic, that I am not so foolish as to assert that without Hahnemann and his followers, medicine would have remained where it was when Hahnemann enunciated his great law of cure. On the contrary, I am inclined to believe that if the law of similars had been presented by one less dogmatic than Hahnemann, and had not been so obscured by mysticism and unthinkable hypotheses, it would long ago have become the working rule of all schools of medicine in the application of drugs to disease.

My second question follows the first in logical sequence: "Has homœopathy fulfilled its mission and should we now permit ourselves to become a part of the dominant school of medicine?"

The spirit of the times is encouraging amalgamation and co-operation in competing corporate, business and philanthropic enterprises, and why should not the great schools of medicine bring themselves into harmony with this spirit? Even theology, which has ever been weighted down by bigotry and dogmas, is learning the great lesson that truth is the prerogative of no denomination and no sect. The modern theologian

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believes with the great Swiss reformer, Zwingli, that the Father of Truths spoke truths to Plato, to Socrates, to Buddha, to Mohammed and to Confucius, as well as to the Founder of Christianity. In this spirit there was held ten years ago during a National Exposition the "World's Congress of Religions." Upon the same platform sat side by side Jew and Gentile, Catholic and Protestant, Mohammedan and Buddhist, Trinitarian and Unitarian, Dogmatist and Free Thinker, Materialist and Transcendentalist. A survey of theological history during the last years of the century just closed reveals a spirit of religious tolerance which should bring the blush of shame to the cheek of him who is the disciple of Hippocrates.

Nevertheless one who sincerely believes that he is advocating a principle and a truth which is destined, when it is fully elaborated and universally accepted, to benefit mankind beyond all human computation, would be a moral coward to salve his conscience for the sake of peace and harmony, or for position. When a great and powerful body, such as is the dominant school of medicine, which has antagonized us for years, which never granted us concessions that were not forced, which bitterly opposed our admittance into state and governmental institutions, suddenly changes front, tears down its high walls of intolerance and exclusivism and receives with open arms "him who thinks, though he thinks error, for, thinking, he may think truth and thereby add to the common fund," it behooves us as custodians of that great principle and that great truth to question the motive, and act with deliberation.

I impugn neither the honesty nor the good intentions of men like Reed and Osler. They have become thoroughly imbued with the idea that homœopathy, possessing, perhaps, a modicum of good, has now outlived its usefulness, and that the rank and file of the members of our school are anxious to renounce our name and abjure our principles for the sake of becoming an integral part of the body medical. They recognize (Dr. Reed says it in so many words) that the homœopathic profession, especially in co-operation with the Eclectic school, is powerful enough to defeat any medical legislation, proscriptive or otherwise, which the dominant school may desire to inaugurate. This condition of affairs, says Dr. Reed, "was brought about under the stimulus of ostracism and the fostering care of public sympathy thereby induced." If, therefore, we will drop our distinctive name, apologize for having so long remained a "sect" in medicine, and promise to commit no lese majesty in the future, we are to be received into the fold of so-called regular medicine.

I am willing to admit that the "unity of medicine" under proper conditions is something devoutly to be desired. But the dominant school of medicine is not yet ready to accept these conditions. They involve a full recognition of homœopathy and the law of similars by all colleges and societies of that school so that homœopathy shall be taught in such colleges as thoroughly and as earnestly as at the present time it is taught in our homœopathic institutions. That time will not have arrived until homœopathy shall have so perfected its peculiar system of therapeutics as to have gained a large number of advocates among the writers and teachers who designate themselves as "regulars." That that time will come in the future there is not the shadow of a doubt, and I shall

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further along endeavor to show how we, as a school, may hasten its advent. Meanwhile some light may be thrown upon current tendencies by citing the experience of a prominent member of an old school faculty in this city, who one year ago, in order to obtain the sentiment of the profession regarding the wisdom of establishing a homœopathic chair in his college, sent a reply postal card to all "regular" physicians in the State of Ohio, asking their opinion on the subject. Nearly every man under forty years of age was in favor of establishing the chair, while almost without exception the older men opposed the scheme. This is valuable testimony, and shows conclusively that it is to the younger men we must look for unprejudiced thought and action.

I have already endeavored to show the impress which homœopathy has left upon the dominant school. But this impress has been general rather than specific. The therapeutics of that school is yet in the most chaotic state. Empiricism of the rankest kind still characterizes its literature and its teachings, even in the application which it makes of homœopathic remedies. Vaunted specifics come and go like the morning dews. To-day some remedy is heralded as a universal panacea for certain diseases and certain conditions; tomorrow it is assigned to oblivion, there to remain with the thousands which have preceded it. This process has continued until the average old school practitioner has become a therapeutic agnostic, so far as internal medicine is concerned, relying rather upon mechanics, dietetics, and prophylaxis, than upon remedies to cure disease.

This is a sweeping arraignment, but testimony in support of it can easily be adduced. No one will, I think, question the standing of Dr. James F. Goodhart, who delivered the annual address on medicine before the 1901 meeting of the British Medical Association. Dr. Goodhart asks the question, "Why do we give drugs?" "Often," he answers, "not because the disease demands them, but because the patient is not happy until he gets them; too often he is not happy then. They are sometimes given to hide our ignorance, I fear, or to mark time while we watch and wait. They are sometimes given as a gambler on the 'Exchange' speculates in futures, an enhanced reputation being the windfall that it is hoped to secure; and then we often give drugs as an experiment in the hope that they may do good."

As to drugs themselves he says: "Diseases run in fashions and so do drugs. Their popularity is enormous, far in excess of their merits; and by and by they sink into the cold shade of neglect. * * * Who does not even now remember the boom of antipyretics. A few of them remained to us for other purposes; but as antipyretics, who gives them now? * * * They were rushed for more than they are worth, and they are now buried by later booms, such as animal extracts and antitoxine, and many of these will be buried, too."

These are not the sentiments of one who has no right to speak *ex cathedra* in the counsels of his school. Dr. Goodhart has but few peers as a writer and teacher. Nor is he a sporadic case. He but echoes the teachings of men like Osler, Tyson and Anders of this country, writers who have produced works classic in all that pertains to the domain of causation, pathology and diagnosis. One has but to pick up

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any modern text-book on practice belonging to the older school to find in almost every chapter confirmation of Dr. Goodhart's agnosticism so honestly expressed.

It is indeed refreshing to turn from the agnosticism and uncertainty which characterize the therapeutics of that school to the precision and the permanency of the therapeutics of the homeopathic school. The indications for bryonia in rheumatism and pleuritic pains were given us nearly one hundred years ago. Bryonia is just as useful to-day as it was then for the conditions enumerated, when the indications prevail. And so it is with hundreds of other remedies based upon a law of nature immutable and unchangeable rather than upon an hypothesis put forth to explain supposed facts and phenomena.

From the standpoint, then, of a homœopathic physician, it is not yet time to surrender either our name or our distinct organization. The law of similars, or if you please, the law of substitution, can no more be separated from the distinctive name of "homœopathy" than can the teachings of Martin Luther be separated from that of the Reformation. In another twenty years the term "homœopathic," which in the past has acted like a red flag flaunted in the face of an angry bull, will not grate upon the ear of progressive and liberal men of whatever school, any more than at the present time do the terms "psychopathic," "neuropathic" and "hydropathic." The school which has so long been thrown into hysterics by the term "pathy" is rapidly being split up into many.

With this single reservation, then, that we shall hold fast to our historic name and to our fundamental principle, we can meet the liberally inclined gentlemen of the older school more than half way in all matters pertaining to the public weal, whether they have for their object the betterment of civic government or the advancement of medical education. There can be no possible objection to affiliating ourselves with their societies, provided that in so doing we are not called upon to renounce either our name or our principles; and if they admit us to affiliation, we, on our part, ought to be equally magnanimous and open the doors of our societies to all physicians complying with the standard educational requirements, upon the same terms. If they advance methods of cure which can advantageously supplant the law of similars, we shall remain receptive and open to conviction. But we believe we still have a mission to perform in perfecting and advancing that law, so that it will be accepted by all schools as a working law in therapeutics. Until that mission is performed, we shall preserve our independence and our identity.

Again, however pleasant may be the relationship existing between the two schools of medicine among the teachers, writers and specialists of the respective schools, especially in localities where homœopathy is strong numerically, this feeling does not prevail in communities where homœopathy is but feebly represented. In order to speak authoritatively upon this subject, I wrote a personal letter to representative members of this Institute residing in various sections of the United States and Canada, asking the following questions:

1. What is the relationship existing between the two professions in your city?

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2. Is the homœopathic profession received kindly in the various hospitals of your city under old school control, and upon the same terms as is the regular profession not connected with the staff of such hospitals? Do the members of the regular profession consult with homœopathic physicians, and do they treat you fairly and squarely?

3. Is there any discrimination made in official appointments? And

4. Do the two professions meet harmoniously and pleasantly in a social way?

A tabulation of the answers to these questions shows that in nearly all cities in which homœopathy is strong numerically, the relationship existing between the two schools is reasonably cordial and pleasant; that consultations between members of the respective schools are of common occurrence, and that the homœopathic profession has access to nearly, if not quite, all the hospitals under old school control. In the city of Cleveland the utmost cordiality and liberality prevails between the two professions, and many of my warmest friends are men of the older school. On the other hand, in sections of the country where homœopathy is not fully established, the bitterest antagonism on the part of the dominant school still exists. Consultations are held but rarely, if ever; homœopathic physicians are debarred from the established hospitals; the grossest discrimination is made in official appointments, and socially there is no intercourse. All this in the year of our Lord 1902, and two hundred and fifty years after Wm. Harvey said, "I claim that liberty, which I willingly yield to others, namely, in subjects of difficulty, to put forward as true such things as appear to be probable, until proved to be manifestly false."

In the face of these facts are we not in duty bound to stand by the many little coteries of men who, in this country and in Europe, are waging an unequal fight for the sake of principles which they believe to be right and just?

Again, in logical sequence, I approach question three.

"What evidence can we put forth going to show that the law of similars, upon which the homœopathic school is based, is a law of nature and a law of cure worthy of being elaborated and studied by all who have at heart the best interests of humanity?"

In answering this question it is necessary to form some conception of what Nature is. I think it can best be defined by the words 'unity" and "harmony." The science of nature is the study of relations by which matter and elements are bound together. Therefore, a new scientific fact is simply the perception of a new relation. A "Law of Nature," then, means a law which fits or matches other well known laws with harmony and precision. "Thus," says Dole, "each new element, as it is discovered, fits into a kinship of elements, where before there had been a gap. The unrevealed thing is not yet a truth till its relationship is found out. As soon as the scientific eye sees with regard to the new flower or tree, the new chemical element, the new planet, that this matches with all other things known; as soon as the astronomer finds that the hitherto supposed disturbance in his calculations is in fact demanded by the law of gravitation, that it heralds the presence of an unknown asteroid, the area of truth, that is, harmonized knowledge, is widened."

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Carrying this beautiful conception of Nature to its logical conclusion, we are forced to believe, even in these days of intense materialism, that an all-wise Creator did not create harmony so complete that "the characteristic of everything natural is that it fits together with everything else" only to leave his children at the mercy of caprice and chance in contending with disease and suffering. Must we see order in one place and chaos in another. "Must we," to paraphrase again from Dole, "stand in wonder at one moment at the marvelous correlation of the machinery and the forces of the world, and then at the next moment be struck aghast at the disorderly results of the working of this Titanic system in the one realm where its working concerns us"—in disease, in life and in death? To me, a physician, the supposed unity of nature avails but little if it merely correlates the several natural sciences into a "poem or symphony" from which nothing can be omitted, and stops short of affording a law of cure which is beneficent and reliable.

But while it is probable that a law of healing exists in nature, it by no means follows that the law of similars is that law. In undertaking to prove that it is, it is unfortunate that all methods of cure must ever remain without the domain of the exact sciences. It is impossible to repeat experiments in the biological sciences as in chemistry and in physics. Even in the exact sciences, as we call them, which deal with facts, we touch forces that we cannot understand. Herbert Spencer has shown that we cannot take up any problem in physics without being quickly led to some metaphysical problem which we can neither solve nor evade. If this is true of the science of physics, how much more true is it of the science of the human organism. In disease no two cases are alike, and it is impossible to make invariable deductions because of the disturbing influences of constitutional bias, race and environment.

I therefore know of no way of proving that the law of similars is a general fact, a principle, a law of nature, except by clinical demonstration. Learned hypotheses may be brought forward to explain a fact, but they still remain hypotheses. We may find it difficult or impossible to explain why a magnetized steel bar when it is encircled by a current of electricity, will move to the right hand or to the left, instead of pointing steadily to the north pole of the earth; but it is a fact, nevertheless, that it will. It is impossible to explain why the ripened apple drops to the earth instead of flying off into space, but it is a fact that it does drop to the earth. It is difficult to explain why oxygen will combine with the other elements only in the proportion of sixteen parts by weight; but it nevertheless remains a fact—a law of nature unalterable and uncompromising. And so it is with the law of similars. It is hard to explain why a remedy which will produce certain symptoms when given to a person in health will cause similar symptoms to disappear when administered in disease. It nevertheless remains a fact, demonstrated beyond all question in the clinic and at the bedside, that it will do so within certain limitations. This one fact is worth more to the agonized mother bending over her sick child than all the theories set forth by all the physicians since the dawn of civilization. It matters little to that mother whether the shibboleth of homœopathy is expressed indicatively or subjunctively, so long as her child is restored

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to health.* The old world is weary of the quibbling over creeds, definitions and formulæ. In any department of thought it is the essence of truth rather than its form of expression that the earnest seeker most cares for. Theories and hypotheses put forth to explain the law of similars "inductively founded upon innumerable instances" only obscure its almost sublime simplicity.

Homœopathy is then, a practical fact to be observed at the bedside. It is simple and intelligible; and it stands upon its comparative merits. There has never been a public trial of it made but that it has gained immeasurably by comparison with the methods of treatment of the older school. Let us enumerate some of its most obvious claims to superiority, which have been emphasized by many writers:

(1) Homœopathy affords a practical guide in the treatment of disease, while so-called regular medicine, as regards therapeutics, notwithstanding its marvelous strides in all other departments, is still in a condition of chaos and uncertainty;

(2) Homœopathy aims at the eradication of disease whenever this is possible rather than merely to afford palliative relief;

(3) Homœopathy economizes the vital powers by administering the minimum curative dose;

(4) The homœopathic physician first learns the properties of drugs by experimenting upon the healthy rather than upon the sick;

(5) The homœopathic physician is therefore better prepared to treat any new form of disease which may present itself than is the so-called regular physician, for the reason that he bases his treatment upon the phenomena of disease rather than upon its essence, and deals with such phenomena inductively rather than deductively.

The foregoing claims are not re-echoed at this time in the spirit of a narrow partisan who can see nothing good beyond the realm of his own school of medicine. On the contrary, I realize that it is becoming more and more the mission of the true physician to prevent rather than to cure disease. I realize, too, that there are many other methods and possibly other laws of cure. I am aware that for infinite ages human beings have suffered and died under all methods of cure, and that the best we can do under the most favorable conditions is too often futile and valueless. These claims are presented for the purpose of comparison rather than from a spirit of boastfulness. If they are substantiated by facts, as I honestly believe they are, let us pass to question four:

"What have been the chief obstacles to the growth of homœopathy and its acceptance by the dominant school of medicine?"

I have already intimated that the growth of homœopathy and institutions homœopathic has been, in many sections of this country at least, far from unsatisfactory. Now, if the law of similars is the best and most universally applicable of all the laws or methods of cure yet enunciated or evolved, as we claim, should it not long ago have been accepted by progressive and scientifically inclined physicians of all schools? Hahnemann promulgated this law at a time when, as later

*There has been much useless discussion by various homœopathic writers as to whether the now historical phrase should read "*Similia similibus curantur,*" or "*Similia similibus curentur.*"—J. C. W.

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experiments proved beyond all peradventure, the treatment in vogue was doing infinitely more harm than good. Hahnemann himself was a physician of acknowledged ability, culture and scientific attainment. He had more than a national reputation as a chemist and a scholar. He was a recognized member in good standing of the so-called regular profession. He published his first observations and experiments in a well-known and recognized journal of his school—Hufeland's; and the law which he enunciated was destined to revolutionize the practice of medicine and pharmacy. Yet it remains a fact that the law of similars is still unacceptable to a great majority of medical practitioners throughout the world. It is our duty, as custodians of this great law, fearlessly to analyze the reasons why this is so. Such an analysis will show that the great obstacles to the acceptance of homœopathy have been two in number. They are, first, the dogmatic and ultra-conservative spirit of scientists in general, second the counter-dogmatism of Hahnemann himself and of certain of his followers.

In approaching the discussion I shall first remind you that the dogmatism of science is and ever has been the most intense of all forms of dogmatism, that of religion not accepted. As John Fiske puts it, "There has grown up a kind of puritanism in the scientific temper which, while announcing its unalterable purpose to follow Truth, though she lead us to Hades, takes a kind of grim satisfaction in emphasizing the place of destination." On the whole this vigorous and rigid scientific temper is commendable and desirable, but if the evidence of truth is not immediately forthcoming; if such evidence conflicts with long existing conceptions of truth, history shows that all innovations destined to promote the welfare and happiness of mankind have ever been contended against by human passions and human prejudices. Thus in 1592 a celebrated anti-religious professor of Padua had so little faith in the discovery of Gallileo that he declined to look through the great astronomer's telescopes in order to disprove the charge of "heresy" which had been made by the church. In 1737 Galvani, when he announced his great discovery, was dubbed "the frogs' dancing-master." In 1743 Lavoisier, a noted French scientist, declared, in discussing the possibility of aerolites: "There are no stones in the sky, and therefore none can fall upon the earth." In 1752 Benjamin Franklin was greeted with shouts of laughter by the Royal Society of Great Britain when he declared the identity of lightning with other electrical phenomena. And as recently as 1822 Daguerre came very near being consigned to an asylum for affirming "that he could fix his own shadow on magical metallic plates." Nearly fifty years after Harvey had announced his great discovery to the world, the Paris Royal Society of Medicine gravely listened to an essay which classed it among the impossibilities. Jenner's great discovery of vaccination, notwithstanding that it affords us security from that horrible and once universal plague, smallpox, is still bitterly opposed by a small minority of educated physicians. Hydrotherapy, while to-day the chief reliance of the older school in the treatment of fevers, was ridiculed for years by that school. Electro-therapy and hypnotism were long practised by irregulars and quacks before the regular profession investigated their worth. And certain men prominent in the profession are to-day emphasizing the inutility, if not the actual harm-

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fulness, of antisepsis and asepsis, even though thousands upon thousands of lives are annually saved by the practice inaugurated by Lister. Such being the attitude of the scientific mind toward all great revolutionary discoveries, it is perhaps not much to be wondered at that the law of similars should make headway but slowly.

One would, however, naturally think that the revolt of Descartes against the scholastic philosophy of the seventeenth century, and that the contributions made to science by Newton, as well as the discoveries of Harvey, Black, Lavoisier and Copernicus would have so prepared the way for the advent of a great and natural law in healing as to have made its reception cordial and its application universal. But it is hard for men of any generation not to be influenced by the prejudices and errors of their predecessors and contemporaries.

In the second place no earnest student of the history of homœopathy can, I think, fail to recognize the fact that much of the opposition with which it has had to contend is due to factors inherent in the teachings of Hahnemann and a small party of his followers. Hahnemann's dogmatism in his older days repelled many who otherwise would have investigated his system. It was a dogmatism begot by persecution, by exile, by poverty, by calumny, by unreasonable and intolerant criticism, and finally by victory and success. This man who drank of the very dregs of poverty for truth's sake, well deserves all the encomiums that you and I who have profited by his sacrifices can bestow upon his memory. The very least that a grateful profession in this great republic could do was to insure the perpetuation of that memory by erecting in our capital city the most beautiful and artistic monument in that city. I cannot say too much for the genius of this great man and physician. His name will be handed down to successive generations as one of the world's benefactors. His writings, compared with the writings of his contemporaries in medicine, were far in advance of his day and generation—a fact which, if anything, intensified his dogmatism. But hypothetical explanations have led more than one great mind into waters too deep for safety. Facts do not fit hypotheses, even though reason says they should. The strength of any chain of arguments is no stronger than its weakest link; and thus Hahnemann, by the use of such terms as "vital principle," "dynamic action," "spiritual" and "potentization," obscured the law of similars with theories based upon hypotheses which, until the end of time, will remain nothing but hypotheses. The law of action and re-action asserted itself here as it ever has done. Hahnemann passed from the gross materialism of his day to extreme infinitesimalism which has ever retarded the recognition which homœopathy long ago should have received.

Had Hahnemann possessed a personality less attractive and a genius less inspiring, it is possible that his dogmatism would not have so thoroughly infected some of his followers. In my mind there is little choice between the dogmatists belonging to the different schools of medicine; at the best the difference is only one of degree. Should I live to be an hundred years old, I shall never forget the impression made upon me by two such dogmatists, while a student of medicine in the University of Michigan, when its homœopathic department was but a few years old. A professor in the department of medicine and surgery, narrow

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and intolerant, made the assertion that "he would rather a patient suffering from intermittent fever would die under twenty-grain doses of quinine than get well under the thirtieth dilution of natrum muriaticum." When the information was carried to a certain instructor in the homœopathic department, he replied that "he would rather a patient would die under a strictly homœopathic remedy than get well under massive doses of quinine." Four hundred years before, these men would have attained to high rank in the Inquisitorship of Torquemada.

Men of this stripe are yet to be found in all schools of medicine, but I am glad to say that they are growing fewer in number each year. It is useless to meet them by bland, unmodified denial, since, as De Quincey says, "all errors arise in some narrow, partial or angular view of truth." They do not seem to realize that the problems of medicine will never be solved once for all, but that each generation has to make its own solution. Those in the homœopathic school are, as a rule, honest and sincere in their convictions, which makes them all the more unreasonable. I have no desire to restrict them in freedom of thought or liberty of action. They should, however, be willing to grant equal privileges to all others. The term "mongrel," when one sees fit to advocate measures other than homœopathic, no longer has a place in the literature of any modern school of thought. The "holier than thou" assumption belongs to the dark ages rather than to the twentieth century. Criticism of the Organon should not be confronted by traditional views and dogmatic statements which decline investigation and revision. Hahnemann's teachings should be accepted for what they are worth to-day, not what they were worth one hundred years ago. New discoveries and innovations in medicine and prophylaxis should be duly investigated and not contended against, as though truth were better subserved by jealously ignoring all without the pale of the law of similars. If that law cannot withstand the searchlight of twentieth century methods, it were better a thousand times over to let it go to the wall than to lose one single life by clinging to an exploded dogma. If you think that I am putting the case too strongly, let me ask you to carry the application to the bedside of your own household!

Personally, I have no fear of such investigations and such comparisons. If homœopathy is what we claim for it, investigation and comparison will but aid us as a school. If it lose by comparison, we should be the first to express our gratitude for better methods. "There is," says Emerson, "a statement of religion possible that makes all skepticism absurd." There is, in my opinion, a statement of homœopathy possible which will purge it of its superfluities and make it acceptable to all thoughtful and intelligent physicians. This cannot be made in a day. Further, it must be done by the homœopathic profession itself. New provings along the lines followed this year by one of our special societies, utilizing, as was done, the microscope, the test-tube and all modern methods of diagnosis, are imperative. We should work for a large endowment to accomplish this end. There is here an opportunity for some of our philanthropic rich to do a world of good for suffering humanity—a fact which we should keep constantly before the public.

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"Is homœopathy losing in numbers, prestige and popularity, as claimed by certain writers of the dominant school of medicine?"

It must be admitted that, since the dominant school has changed its attiude toward what it pleased to term the "sectarian schools," a considerable number from the homœopathic ranks have taken degrees from so-called regular colleges. Down to five years ago, with two or three exceptions, converts from homœopathy to the dominant school were almost unheard of, whereas converts from that school to homœopathy were many. The new order of things was therefore proclaimed far and near as conclusive evidence that homœopathy was dying, if not dead. In order to controvert this statement, I wrote to all of the homœopathic colleges in this country asking for the number of graduates and students of regular colleges who have, during the last five years, received degrees from homœopathic colleges. I find that during this period two hundred and eighty-four men and women, coming from the ranks of regular colleges and schools, received degrees from eighteen homœopathic colleges in the United States, with two colleges to hear from. During the same period of time, there has been a total of one thousand nine hundred and thirty degrees conferred by the same colleges. Let the gentlemen of the older school, who annually "bury" homœopathy, ponder over these figures. We have so often been killed and "buried" by our enemies that the process is becoming rather agreeable than otherwise. We revive with alacrity, and continue to press the electric buttons which open the doors of the wealthy and the cultured throughout the land. I ask in all earnestness if it were possible for any advocate, no matter how ingenious and plausible, to inaugurate a system of medicine which could survive one hundred years of criticism and persecution, becoming, as it has, a great power in this free land of ours, were it not founded upon a great truth rather than upon a mere hypothesis? In spite of the most unjust legislative restrictions which prevail in nearly all foreign countries, homœopathy has established itself in every civilized community on the face of the globe. Homœopathy is neither dead nor dying, but, on the contrary, is daily gaining in prestige and popularity.

Finally, "What should be our attitude toward the dominant school of medicine and toward innovations in medicine?"

In answering this question it is first necessary to define the legitimate sphere of homœopathy and its limitations. I discussed this phase of the subject in an address which I had the honor of delivering before this body three years ago, and as Dr. Dake so concisely expressed my views I quoted from him as follows:

1. "The homœopathic law relates to no agents intended to affect the organism chemically."

2. "It relates to none applied for mechanical effect simply."

3. "It relates to none required for the development or support of the organism when in health; and

4. "It relates to none employed directly, to remove or destroy parasites which infest or prey upon the human body."

To this series of propositions I would add:

1. It relates to none which act in a purely eliminative way to rid the system of poisons and ptomaines.

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2. It relates to none which act in a purely physiological way, as a food; and

3. It relates to none which act in a purely stimulative way.

I believe that an explanation such as the foregoing, fairly and squarely expressed, will disarm criticism and extend the usefulness of homœopathy. It places our school upon a broad and liberal foundation, which will appeal strongly to all earnest students of medicine. It will limit the law of similars to its legitimate sphere of action—the curing of diseases which are curable by the principle of substitution, and leave its advocates free to utilize all methods of cure or relief which will best subserve the interests of the patient. There are, to be sure, men who will claim that the homœopathic remedy is all-sufficient for all conditions. If these gentlemen have become so proficient as to require nothing without the domain of the law of similars in contending with disease and suffering, they are to be congratulated; there are comparatively few of us who possess the knowledge to do so. Personally, I believe it the duty of the physician, first to prevent disease, if possible; secondly, to cure disease which he cannot prevent by the safest, surest and easiest method at his command; and, thirdly, to bring comfort and relief to the incurable by those means which are most available and most satisfactory, whether homœopathic or otherwise. This course leaves a wide scope for the application of the homœopathic law, while it broadens our conception of the healing art. We are physicians first, and homœopathists secondly.

Watts once said: "The mind which is searching for truth ought to remain in a state of suspense, until superior evidence on one side or the other inclines the balance of the judgment and determines the probability and certainty to the one side."

Unfortunately all truth cannot be put into the forms of a mathematical proposition, and "he who would master any truth must learn what a jealous mistress he must serve."

How much more inspiring would have been the history of medicine had these trite sayings been kept in mind by the men who have gone before. How much more honorable will the history of the future become if we now heed them and purge the profession of its dogmatism, bigotry and intolerance. "Scientific inductive research," says Tyndall, "requires patient industry, and a humble and conscientious acceptance of what nature reveals. The first condition of success is an honest receptivity and a willingness to abandon all preconceived notions, however cherished, if they be found to contradict the truth."

The medicine of to-day is but the consummation of the medicine of the past ages, and infinitely more is expected of us than of our forefathers. Much more is being accomplished than formerly without the use of drugs. Prophylaxis is no longer what the Platonic Atlantis was to the Greeks—a mythical land of unfulfilled promises. The wonderful conquests of surgery are the marvel of the age. The germ theory of disease has revolutionized the practice of both medicine and surgery. Pathology is rapidly finding its place among the exact sciences. Microscopy, hæmatology and siagraphy have added much to the certainty of diagnosis. Notwithstanding these wonderful strides our frequent failures at the bedside ought to make us modest and thankful for any new

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method or system of cure which promises to benefit mankind. We are as yet able, in our efforts to comprehend that which pertains to the essence of life, and the dissolution of human beings, which we call death, to penetrate little beyond structural appearance and functional phenomena. We can classify neither an idea nor an ambition and much patient research remains yet to be made in the field of psychology. We are still groping our way in darkness in dealing with the great primeval and ultimate facts—the beginning and end of life. Haeckel and others have undertaken to solve the problem from the standpoint of materialism but have dismally failed in their efforts to do so. In view of these limitations, can we afford to be narrow and dogmatic in our efforts to conserve life and assuage suffering?

The medicine of to-day needs, more than all else, men like Lyman Abbott, Phillips Brooks and Archbishop Ireland to liberalize it. No sincere and educated physician belonging to any school should be ostracized because of his particular belief in therapeutics. The one standard should be that of knowledge, character and professional conduct. The real sectarians in either religion or the sciences are the intolerant and the bigoted.

I believe with Richard Henry Savage that, "there is no man, no sect, no single school, which can in these broadening days of intelligence tie down the human hearts of the twentieth century to any bounden or groveling belief."

"We have a debt," says Emerson, "to every great heart: to every fine genius: to those who have put life and fortune on the cast of an act of justice; to those who have added new sciences; to those who have refined life by elegant pursuits." That debt was formally acknowledged by this Institute when, in 1899, it adopted the following definition of a homœopathic physician: "A homœopathic physician is one who adds to his knowledge of medicine a special knowledge of homœopathic therapeutics. All that pertains to the great field of medical learning, is his, by tradition, by inheritance, by right."

At the conclusion of his address, Dr. Wood was presented with a large basket of American beauty roses, and the audience applauded enthusiastically.

Dr. E. B. Hooker: Our exercises will close with the benediction of Dean Williams.

The assembly arose while the Very Rev. Charles D. Williams, D. D., pronounced the benediction:

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SECOND DAY

WEDNESDAY, JUNE EIGHTEENTH
1902

President Wood opened the second day's meeting promptly at 9:30 a. m.

THE PRESIDENT: The Chairman of the Board of Censors not being present, the first order of business is the report of the Committee on the Revision of the Constitution and By-laws, Dr. T. Y. Kinne, Chairman.

DR. THEO. Y. KINNE: Mr. President, perhaps it is well that I should make a short verbal report before coming to the matter in hand. The Committee was hampered a little by one of its original members being so engaged in other work as to be unable to serve. The President, in his prerogative, appointed another in his place. We sought the advice of men in various sections of the country who are conversant with the affairs of the Institute. We have tried to do that which was best for all concerned, individuals and the Institute, and we present you the result of our labors. Mr. President, perhaps it might expedite matters if I should ask you to receive our report and that it be acted upon *seriatim*.

THE PRESIDENT: A motion is in order to receive the report. Receiving it does not adopt it.

DR. GEO. ROYAL: I make that motion.

Motion seconded and carried.

DR. T. Y. KINNE: The Committee recommends no change in Article I. "ARTICLE II. *Members.* The Institute shall consist of a central body and sectional societies whose members shall also be members of the Institute." That is offered.

THE PRESIDENT: The motion is to take up the report and adopt the change in Article II. Is it the pleasure of the Institute to adopt this change?

DR. N. B. DELAMATER: I move its adoption.

Motion seconded and carried, and the Article declared adopted.

DR. T. Y. KINNE: Permit me to say, by way of premise, that wherever in this report you find the word "general" it is stricken out. Wherever the word "section" occurs it is changed to "bureau." And let me say that this is done in order that there may be no confusion in words, as the affiliated societies are known as Sectional Societies, and we changed the word "Section" in our Constitution and By-laws to "bureau," that there might be greater distinction. I will now read Article III., as we propose to amend it:

"The officers of the Institute shall be a President, two Vice Presidents, who shall be designated first and second, a Secretary, a Treasurer and Registrar, with such other officers as shall be designated by the by-laws, to be chosen at such time, in such manner, for such period, and with such duties as the by-laws shall ordain."

It was moved and seconded that the article be adopted. The motion was carried and the article declared adopted.

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DR. KINNE: No change in Article IV. or Article V. of the Constitution. By-laws: No change in Article I. of the By-laws. In Article II., Section 1, this change is offered by addition: "Strike out the words '*the first of January following,*' and insert these words: 'at the close of the session at which they are elected, excepting the Secretary, whose term of office shall expire upon the first day of January following.'" That is to be added to Section 1.

DR. O. S. RUNNELS: I move the adoption of the change.

The motion was seconded and carried, and the *Section* as changed was declared adopted.

DR. T. Y. KINNE: In Article III., Section 3, add this, so that the latter part will read: "It shall further be the duty of the Secretary to send to each Homœopathic journal published in the country, within two weeks after the adjournment of the annual meeting, a list of the officers for the ensuing year, together with the officers of the Sectional Societies." We offer that.

DR. O. S. RUNNELS moved the adoption of the amendment, the motion was seconded, carried, and the *Section* declared adopted as amended.

DR. T. Y. KINNE: Strike out Section 4.

It was moved and duly seconded that the proposed change be adopted. The motion was carried and the section declared stricken out.

DR. T. Y. KINNE: I will read Section 5 as it will appear as amended as we propose: "It shall be the special duty of the Secretary to make or provide stenographic reports of all scientific discussions of the Institute and of its sections, and of all debates on the reports and papers presented by the standing committees." Now, strike out the rest. Then we come to this: "The compensation and necessary expenses connected with such reports shall be paid by the Institute upon the presentation and approval of the certified accounts."

Dr. W. C. Richardson moved the adoption of the proposed change, the motion being duly seconded.

DR. C. B. KINYON: I simply want to ask a question. I do not know that I have any objection to this at all, but do I understand by this that all reports or notes taken by the stenographers are to be referred to the Secretary to be published or accepted without the author having anything to say about it?

DR. T. Y. KINNE: The transactions, the business and discussions, the Publication Committee have nothing to do with.

DR. O. S. RUNNELS: Then who does revise the remarks?

DR. T. Y. KINNE: They can be revised by those who make the remarks at the time of the meeting, or, if there is opportunity, they can be revised or corrected afterward.

DR. O. S. RUNNELS: It strikes me this needs careful attention for the reason that these reports have often been inaccurate, and I, for one, as my speeches have come back to me, have been unable to recognize them. I should much dislike to go into print as I have been reported many times. We must know that this is right before it goes in. If it is an actual verbatim report, well and good, but they are not verbatim reports, and I think this matter ought to be thought of. We should either eliminate the discussions entirely, or else have them appear as they are delivered.

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DR. BUSHROD W. JAMES: I have suffered, as Dr. Runnels has, in having things that I have said reported contrary to my own expressions. I like to be correctly reported. I would like some method by which the reports could be had within two weeks or so of the meeting. Then let the Secretary have them in hand, so that he can get out the Transactions.

DR. W. C. RICHARDSON: Mr. President, perhaps in the case of Dr. Runnels and Dr. James it is true, but I am aware of the fact that the discussions frequently go back to their authors very much improved by passage through the hands of the stenographers. While I desire to be reported correctly in scientific discussions, I want to say that there should be something done to remedy this interminable delay that causes our Transactions to appear in our hands and on our desks a week or so before the next meeting of the Institute. I understand that the chief delay is in sending out of copies of the reports, and having them held by the speakers. Now, if the Institute sees fit to provide a time within which they shall be returned, or go in as taken on the spot by the reporter, then I am satisfied. If they are not returned, say within two weeks, then the reporter ought to be the one who is the authority as to what was said, and not the speaker.

DR. GEORGE ROYAL: I want to emphasize what Dr. James and Dr. Runnels have said. The discussions are frequently the best part of the proceedings, and we want our discussions accurately reported. I think if an amendment could be put in giving two or three weeks to members that would cover the matter. But it does seem to me that we do not want to omit the discussions; and I know that we ought not to publish discussions that are haggled, as many of them have been, by the reporter.

THE PRESIDENT: The Chair will entertain an amendment to the amendment, if you want to change it.

DR. BUSHROD W. JAMES: I will offer an amendment that the Secretary be instructed to immediately furnish the reports of the discussions to members who have taken part in the discussions, they to have two weeks to have the returns brought in from those who have debated.

DR. GEO. ROYAL seconded the amendment of Dr. James.

DR. E. V. VAN NORMAN: I would like to say that if it is two weeks it would be impossible to get the report to San Francisco or Los Angeles and return within the time desired, and we consider that California has a right to be heard. Make it four weeks.

DR. JAMES: I will modify my motion and make it four weeks instead of two, on account of the distance.

DR. FRANK KRAFT: I desire to call attention to the very thing you are striking out: "He shall send copies of the scientific discussions for revision and correction to their authors respectively, who shall be required to return them within one week after their reception." What more do you want?

DR. W. C. RICHARDSON: Four weeks.

THE PRESIDENT: Will Dr. Kinne kindly read the amendment as amended, so that we may have it consecutive?

DR. T. Y. KINNE: Under the question of the amendment to the amendment this section will read thus: "He shall send copies of these

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scientific discussions for revision and correction to their authors respectively, who shall be required to return them within four weeks."

THE PRESIDENT: Are you ready to vote?

DR. KINNE: May I say one word in closing?

THE PRESIDENT: Dr. Kinne.

DR. KINNE: It is right and proper that the Institute should know the reasons that actuated the Committee in these changes. While this has been a law of the Institute for years, it has taken one and two months to get these revised reports back from their authors, and in some cases they have never been returned. Now, ladies and gentlemen, if you act in this way, if you say all revised reports not received within a certain time shall be placed in the Transactions as the Secretary has them, then that may be a whip to bring them in. The Secretary, human as he is, would hardly dare appear at the next session of the Institute if he took it upon himself to drop out a discussion that had not been returned to him revised. That is the reason why the Committee placed it as it is.

THE PRESIDENT: Are you ready for the motion?

DR. D. A. MCLACHLAN: I feel the force of Dr. Kinne's remarks in this matter, and I should like to see them embodied in this amendment.

DR. KINNE: Then simply place after the word "reception" the words "otherwise they shall be printed as taken down at the time."

THE PRESIDENT: That is a very good amendment.

DR. W. C. RICHARDSON: I move that as an amendment.

DR. B. F. BAILEY: I second it.

DR. KINNE: Then the Secretary has the authority of the Institute, and he can say, "Gentlemen, the other man did it, and not I."

THE PRESIDENT: A vote is necessary on the amendment. Read it as it will appear.

DR. T. Y. KINNE: "He shall send copies of these scientific discussions for revision and correction to their authors respectively, who shall be required to return them within one week after their reception; otherwise they shall be printed as taken down at the time, when they shall be furnished to the Secretary for publication in the Transactions."

DR. O. S. RUNNELS: I rise to a point on this. Some of this matter comes to the Secretary in bad shape, very bad language and in unscientific form. In that case I think the Institute should empower the Secretary to put it in good shape, to edit it.

THE PRESIDENT: The Secretary has that power; there is no question about that.

DR. RUNNELS: If he has that, let it be understood then.

THE PRESIDENT: That is understood; the Secretary will use his discretionary power regarding that.

The question was called for.

THE PRESIDENT: The question is called for. As many as are in favor of the adoption of this amendment will signify it by saying Aye. Contrary minded, No. Carried.

THE PRESIDENT: The Chair desires to announce that all nominations for officers of the Institute are now closed. The Secretary will please read the nominations.

THE SECRETARY read the nominations as follows:

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For President—Dr. Joseph P. Cobb, Dr. Edward Beecher Hooker, Dr. William H. Hanchett.

For First Vice-President—Dr. James W. Ward, Dr. H. F. Biggar.

For Second Vice-President—Dr. M. Belle Brown.

For General Secretary—Dr. Frank Kraft, Dr. Charles Gatchell.

For Recording Secretary—Dr. J. Richey Horner.

For Censor—Dr. Millie J. Chapman.

For Necrologist—Dr. C. A. Weirick.

THE PRESIDENT: Now, Dr. Kinne.

DR. T. Y. KINNE: There is a further amendment to this Section 5, thus, it is an addition: Strike out the last sentence in Section 5, which begins "compensation for such services," and insert this, "the compensation and the necessary expense connected with such reports shall be paid by the Institute on the presentation and approval of the certified accounts."

A member moved the adoption of the amendment. Motion seconded and carried.

DR. T. Y. KINNE: "Strike out Section 6 of Article III."

It was moved and duly seconded that the amendment be adopted. The motion was carried and the amendment adopted.

DR. T. Y. KINNE: Section 8, after the words "there shall be elected annually," strike out the word "a" and insert the word "the." This is done for the reason that as it now is it involves tautology. The officers of the Institute include a Registrar. Now, this section had been added when the Registrar was originally appointed, without putting him in with the list of officers, so we struck that out because it is unnecessary.

It was moved and duly seconded that the amendment be adopted, and the motion was carried.

DR. T. Y. KINNE: "Article VI. *Bureaus.* The following Bureaus shall be appointed as hereinafter provided for:

Materia Medica and Therapeutics.

Clinical Medicine and Pathology.

Pedology, and

Sanitary Science and Public Health.

It will so read as amended.

DR. J. H. MCCLELLAND moved the adoption of the amendment. The motion was seconded.

DR. N. A. PENNOYER: I would like to inquire if it is the intention of this body to prevent the general practitioner, who is a member of this Institute, from receiving anything under the department of the Obstetrical, Gynecological and Surgical Society, in the general Sectional Societies in these different departments. Sectional Societies will furnish more or less technical papers. I believe that the general practitioner should receive in the Institute proper certain reports on all departments, especially medicine, and I would like to hear that point explained.

THE PRESIDENT: Dr. Kinne will offer the explanation.

DR. T. Y. KINNE: I admit the doubt which would arise in your mind, sir, as we passed from one Section to another, but later there will

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be an amendment offered by which the Presidents of the Sectional Societies shall report to the Institute as a body, in their various sectional work.

DR. J. H. MCCLELLAND: Mr. President, it will also be observed that under the bureau of *Clinical Medicine and Therapeutics* any paper can be offered to the Institute that has a bearing on the subject of treatment in any particular branch. Any paper that includes therapeutics in any branch may appear under those heads. It excludes nothing.

THE PRESIDENT: Are you ready for the question?

DR. BUSHROD W. JAMES: One moment. This brings up the question of the publication of the Transactions of the Sectional Societies. Everybody will want to have all the papers of the Sectional Societies. They will be considered as part of the Transactions of the Institute. If they are cut out, any one may well say, "Well, I am interested in that branch, and I want them all in." Now, where are we going to limit it? There should be some method by which we should give the gist of the proceedings of the Societies in our Transactions.

THE PRESIDENT: Has the Committee made any provision for this? If so, will Dr. Kinne kindly explain?

DR. T. Y. KINNE: I will. In this Article as we offer it there is to be this Section included: "The president of each Sectional Society shall present to the general session from time to time such matters as may be of general interest to the profession." We have provided for it in that way.

THE PRESIDENT: Does that answer the question?

DR. WILSON A. SMITH: Doesn't that leave it solely to the judgment of the presiding officers of the Sectional Societies?

DR. D. A. MACLACHLAN: I suggest that this will come up later. If the committee has provided for it, why should we discuss it now?

DR. B. F. BAILEY: I believe it is necessary for us to know this before we can vote intelligently. The question is simply this: Will the Transactions of the American Institute of Homœopathy appear without any work in these Sectional Societies? That is what we want to know.

DR. O. S. RUNNELS: Mr. President, for three years we have been running Sectional Societies, and the work of these Societies has appeared in separate volumes; the Institute has had nothing of them at all. Now, this is a very broad question. It may take some time to settle it. We may have to go through some experience before we can get it settled properly. At present the members of the Sectional Societies not only pay $5 to the American Institute for dues, but they go over to the Sectional Societies and pay $5 additional for the privileges of those Societies in order to get their Transactions. Now, we are trying to mature a plan whereby all can be served in an equable way, so that the general practitioner, or the member who comes and pays $5 to the Institute alone, shall not reap a larger advantage than the member who is paying his $5 for the two.

DR. A. B. NORTON: I understand Dr. Bailey to say that we cannot act intelligently upon this matter until we know what is intended.

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I see no objection to the Committee simply reading what they propose to offer later, and then we can discuss it if necessary.

THE PRESIDENT: I see no objection to that, if the Committee agrees to it.

DR. T. Y. KINNE: No, sir, we have no objection. This revision provides that the Presidents of the Sectional Societies shall hand in their papers, reports and discussions to the Publication Committee of the Institute. Then, when it comes to the Committee on Publication, they will take hold of the matter.

DR. E. F. BAILEY: How will this be done?

DR. T. Y. KINNE: As they have done before, Dr. Bailey. We have always given full scope. Perhaps it would be well if I ask you simply to look at the papers that you hold in your hands. It is in Section 11, under what we know as the amendments offered by Dr. Runnels, and is this: "Each Sectional Society shall prepare its proceedings for publication and report the same to the Publication Committee of the Institute within sixty days after adjournment."

DR. B. F. BAILEY: There are matters that should be taken up in connection with the motion which is before us, and still they cannot now be discussed. For that reason I suggest that the matter be passed for the Committee to submit these two sections in their report together, so that one might discuss certain matters bearing upon it without being out of order.

DR. W. C. RICHARDSON: There is one thing in this connection which I think should be attended to at this particular time. This is a homœopathic society, I understand, and I am much averse to seeing the bureau of Materia Medica put off until the last day.

DR. T. Y. KINNE: If the Doctor will look at the *schedule* on the bottom of the page he will see that it has provided that materia medica shall always come on Wednesday.

DR. NORTON: I would like to ask one more question of the Committee which has charge of this matter, if they have made provision for increasing the dues of the society. The annual report of the Treasurer just presented stated that we have a balance, I believe, of $300. Now, the matter of the publication of the additional Transactions of these Sectional Societies will necessarily increase the expense of the American Institute membership. I do not believe it is wise for the Institute to have its dues increased. If we charge $7 it will be $2 more to the general practitioner, and $3 less to the specialist. But this is placing a tax on the general practitioner, and removing it from the specialist. Now, with our present surplus I do not see how it is possible to publish the additional transactions by the Institute without increasing our dues. The O. O. and L. Society last year published a volume of 385 pages. The Surgical Society, about 200 pages. That is 500 additional pages to our present Transactions. What the Therapeutics, and Obstetrical, and all the other Societies are going to do I do not know, but it would necessarily make a volume two or three times the present size to have all the additional transactions. How are you going to meet that?

THE PRESIDENT: Dr. Kinne, will you answer that question?

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DR. KINNE: Yes, I will try. That brings out something that I did not propose to present just now, because under the rules it should lie over for a time. You will pardon me if I read this resolution which was intended to cover what Dr. Norton has just said. The resolution provides that, in addition to the Transactions that have always been published, whenever any Sectional Society desires its Transactions published separately in full, the Publication Committee is authorized so to do at cost price, provided payment for 75 copies is guaranteed. It is so done in the American Medical Association. That will lessen the dues of the Sectional Societies. I understand your dues are to pay for the publication of the Transactions. It will bring them down to a minimum, about one-third or one-half of what you now pay, and this resolution, which I intended to offer a little later, was intended to cover that point.

DR. A. B. NORTON: I fail to see how it covers the point. We have first got to publish these Transactions, according to the present amendment offered by the Committee, by the Institute as a whole. It is not the cost to the specialist; it is the cost to the Institute. The Committee proposes at present to publish all the reports and discussions in one volume of Transactions.

DR. B. F. BAILEY: No.

DR. A. B. NORTON: I call for the reading again of the amendment in regard to the publications.

DR. J. H. MCCLELLAND: I sympathize with Dr. Norton and others who are anxious to guard against something that may come up later, and to meet that I would move that the committee read all these amendments as a whole, and then that afterwards we take them up *seriatim,* and we will know definitely what is coming, and be ready to vote on it.

THE PRESIDENT: That motion is out of order. There is a motion before the Institute, and we will have to take some action on that motion before Dr. McClelland's motion is in order.

DR. J. B. G. CUSTIS: I suppose I am speaking to that amendment as it has been amended. Now, to provide practically for the admission of the reports of the Sectional Societies to the Institute Transactions, that is what it does, practically.

DR. T. Y. KINNE: We have not yet come to that, and that is why I am anxious to get light on the subject. I look upon this whole movement as dangerous. I do not understand the motive, and I think the general practitioner is the one to be injured from beginning to end. You ask the general practitioners to join this association, and you practically take away all his privileges. The general practitioner is the most modest of men. You invite him into the Sectional Societies, giving them sectional names. He does not have the liberty of the floor unless it is especially given to him. He comes to the Institute, and can discuss the thing on an equality with every one else. That is one way by which we are going to keep members out of the association, by adopting these amended by-laws. I have talked with these men. Now, the specialists, while we love them, individually, we do not think they are the ones to run the practice of medicine, and they are trying to do it by

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just such amendments as this. And why? It all comes down to the matter of expense. Dr. Runnels has told you all about it.

DR. O. S. RUNNELS: No, I didn't tell them all.

DR. J. B. G. CUSTIS: You were offering to do it. Now, I want to know something about the history before I go on with the case. We will speak some more about this as we go along, but I want to warn the members about doing this without proper deliberation.

DR. GEO. ROYAL: I am a general practitioner, and, as Dr. Kinne says, a modest man, and yet I do not believe but what I can be recognized on the floor of the Sectional Societies. I have no fear whatever as a general practitioner that my rights will be curtailed by this plan, and I thoroughly believe it will be the best thing that can be done for the American Institute. Now, just a word in regard to the price. As I understand the plan when completed, the Bureau of Obstetrics, as it is now, will be in a section, as well as Gynecology, which is duplicated, and which take up a number of papers, will be out of the way, and we will get our Gynecology and our Obstetrics and Electro-Therapeutics and Nervous Diseases in with the sections. It seems to me that a way can be devised by this body so that these will come into our Transactions, and add very little extra expense; and if there is a little, I believe we general practitioners are willing to pay it.

THE PRESIDENT: The Chair would suggest that Dr. Kinne now read the remainder of his report through. That is what we should have done at the beginning. It is the only thing to do, because you cannot act intelligently upon these sections without knowing that which is to follow. Dr. Kinne, will you kindly do that?

DR. KINNE: Certainly. You will notice that we have proceeded as far as Article VI. I will repeat it. It reads: "The following bureaus shall be appointed as hereinafter provided for: (a) *Materia Medica and General Therapeutics;* (b) *Clinical Medicine and Pathology;* (c) *Pedology, and* (d) *Sanitary Science and Public Health.*" We pass on. Section 2 will only change a word. Section 3, struck out. Section 4, struck out.

DR. RICHARDSON: What are you reading from?

DR. KINNE: I am reading from the present by-laws.

DR. RICHARDSON: But you are not reading the proposed amendment.

DR. KINNE: Not at all, sir. When I come to an amendment I will read it.

THE PRESIDENT: It is amended by simply striking out all these sections.

DR. KINNE: That is all. Section 5, strike out and insert this: "And the Presidents of the Sectional Societies shall also conform to the requirements laid upon the Chairmen of the Bureaus in the matter of making report to the Secretary." Section 6, for euphony: "No member shall be appointed to more than one Bureau in any one year." It is simply taking the place of "No member shall serve on more than one bureau." Section 7, as it is. Of course, gentlemen, these "Sections will have to be renumbered, which can be done by the Secretary afterwards. I am reading them as they are here. Now, at the close, add this: "The Institute shall recognize the following Sectional Societies

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as part of its body: (a) *Surgical and Gynecological Society of the A. I. H.;* (b) *Ophthalmological, Otological and Laryngological Society of the I. A. H.;* (d) *Obstetrical Society of the A. I. H.;* (e) *Electro-Therapeutical Society of the A. I. H.;* and such other societies as may be formed from time to time under the rules and regulations of the Institute." That is the section to be added. Section 6. "Each Sectional Society shall perfect its own organization and make its own constitution and by-laws, elect its own officers, and conduct its own deliberations. It shall have self-government, so far as its organization and conduct of its affairs is concerned, but shall be strictly under the rule of the Institute in all matters of publication and other requirements of general welfare." New Section 7. "The meetings of the Sectional Societies shall be held annually at the same time as the Institute, but shall not conflict with the sessions of the Institute except as permitted by the Executive Committee of the Institute." Section 8. "The President of each Sectional Society shall present to the general session from time to time, such matters as may be of general interest to the profession."

Section 9. "Each Sectional Society shall prepare its proceedings for publication and report the same to the Publication Committee of the Institute within sixty days after adjournment."

Section 10. "No Constitution or By-law of any Sectional Society shall in any manner conflict with the Constitution or By-laws of the Institute."

Article VII. Committees. Strike out Section 1 and insert the following: "(a) *Organization, Registration and Statistics;* (b) *International State Committee;* (c) *International Bureau of Homoeopathy;* (d) *Inter-Collegiate;* (e) *Drug Provings;* (f) *Committee on Medical Examining Boards.*"

Section 2. "Committee 'B' shall consist of two members from each State, to be appointed by the respective state societies, provided such appointees are members of the Institute; the Chairman shall be elected by the committee. Committee 'D' shall consist of two delegates to be appointed by each College represented in the Institute, and shall appoint its own Chairman. Committee 'E' shall consist of five members, one to be appointed each year, and the term of service of each member of this Committee to be five years. The remaining standing committees shall consist of at least five members each, who shall serve for one year."

Section 4, strike out the words: "Immediately upon presentation and disposition of its report."

Article XI., Section 7, strike out the words: "And the determination of the next place of meeting of the Institute." The remainder the same.

Now comes another section, which will be numbered; it is a new section. "The nominations for the next place of meeting shall be made on the second morning of the session, Sundays excepted, at ten A. M., in the following manner: Nominations shall be made in open Institute and reported to the Executive Committee, who shall investigate and select three which in their judgment are most desirable. The committee shall, in the month of October following, issue a circular to each mem-

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ber of the Institute descriptive of the various places nominated, together with a return postal card addressed to the Secretary, upon which each member shall record his vote. The polls shall be open for thirty days from the date of mailing the circulars. The vote shall be counted by the Executive Committee, and the place receiving the highest number of votes shall be the place for holding the next meeting."

THE PRESIDENT: Dr. Kinne, what I am about to propose is somewhat irregular and out of order, but Dr. McClelland has made a suggestion that strikes me as a very good one, and that is that we have to-day this report printed as it will appear after the changes and amendments are made, so that we can take the matter up tomorrow morning, and act upon it more intelligently than we can at the present time.

DR. J. H. MCCLELLAND: I would offer a motion that the Committee be instructed to have their report printed as it will appear consecutively, so that the Institute may be furnished the report in the morning.

THE PRESIDENT: The motion of Dr. McClelland is before the Institute, which was properly seconded.

The motion carried, and the Secretary was instructed to prepare complete printed copies of the Constitution and By-laws, with the proposed amendments.

THE PRESIDENT: All in favor of this motion signify it by saying aye. Contrary minded, no. Carried. The Chair will entertain a motion to make this the regular order of business tomorrow morning, immediately after the election of new members. The motion was made, seconded, and carried.

THE PRESIDENT: We will now receive the report of the Board of Censors, Dr. Millie J. Chapman, Chairman.

DR. MILLIE J. CHAPMAN: The Board reports favorably on the sixty-three applicants presented yesterday.

DR. T. Y. KINNE: I move that the report of the Board of Censors be accepted, and that the persons whose names appear therein be elected members of this Institute.

Motion duly seconded, and carried.

DR. MILLIE J. CHAPMAN, for the Board of Censors, reported 44 applications for membership.

THE PRESIDENT: The report will be received and take the usual course.

THE PRESIDENT: The Chair will announce as the committee to conduct the election, Dr. C. B. Kinyon, of Ann Arbor, Mich.; Dr. W. J. Hawkes, of Los Angeles, Cal.; Dr. J. Herbert Moore, of Brookline, Mass. Next is the report of the Committee on Life Insurance Examiners, Dr. A. W. Bailey.

DR. A. W. BAILEY then read the following report:

TO THE OFFICERS AND MEMBERS, AMERICAN INSTITUTE OF HOMOEOPATHY: Your Committee on Life Insurance Examiners would offer the following report. Taking up the work the first of the year, where the former committee left it, we have followed rather closely the plan of the last two years, namely, one of education, and while we have been considering the best methods of securing our desires, several inquiries have arisen in our minds.

First, are the reports that Life Insurance Companies legislate

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against us as a school, true? Some of these Companies have said to former Committees, as per their reports, that they do not discriminate against us; other Companies have not answered the question squarely, endeavoring not to commit themselves, while some have neglected to return any answer.

It is, however, generally accepted as a fact by our physicians, that most, if not all, of the old-line Life Insurance Companies do to some extent endeavor to make as few appointments as possible from the membership of our school, and very rarely, if ever, make such appointments without urgent request, and these requests must frequently be urged from not only a professional standpoint, but from a business standpoint as well. Are these doubts justifiable?

Ten or twelve years ago it would have been an easy matter to have answered such questions, for scarcely could a state or national meeting of homœopathic physicians be held, but that several were present who could, and were willing to state how, some Insurance Companies had treated them unjustly. But it appears to your committee that either this discrimination has grown very much less, or is now worked by the Life Insurance Companies in a more subtle manner, for the same statements that were made so frequently ten or twelve years ago, are not made to the same extent to-day.

Two years ago the committee issued 5,000 circulars to the profession, and had this circular printed in several of our medical journals. At the close of this circular was the following request: If any physician has made application to any company to become an examiner, and has been denied, or having been appointed has had no examinations, or very few, to make, will kindly report the facts of the case to this committee, we will investigate it, and use our influence to set matters aright. (Report, Committee Life Insurance Companies, Transactions 1900, page 4.) The committee received no complaints, which proves one of three things, either there were no complaints to make, which we doubt; or the circular was not read to the extent that the committee desired, which we fear is a fact; or that our homœopathic physicians are somewhat careless in the matter of pushing themselves forward as Life Insurance Examiners, which we do not wish to believe. We now make the offer made by the committee of 1900.

Your committee is convinced that much solid progress has been made, and that the same amount of opposition and neglect is not offered by Life Insurance Companies, as we met ten years ago, and that the work of the Life Insurance Committee is gradually bringing results.

The plan suggests that our colleges should give a special course of lectures on Life Insurance Examiners has been considered by several of our colleges, and at least one has adopted it. We earnestly hope the other colleges will seriously consider the subject.

A number of our State Societies now are working with the Institute Committee, and we feel that the general plan of work suggested two years ago, with whatever modification may be necessary, should be pushed by this and the following committees, and by a general popular expression obtain from the Life Insurance Companies the recognition that we desire.

Respectfully submitted,

A. W. Baily, *Chairman.*

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THE PRESIDENT: What will you do with the report on Life Insurance Examiners?

DR. JAMES: I move that it be received and referred to the Committee on Publication.

Motion duly seconded and carried.

The Board of Censors presented five additional names of applicants for membership.

THE PRESIDENT: The report will be received and take the usual course. Dr. Kinne has two resolutions which he desires to offer, so that they can be considered with the resolutions tomorrow morning.

DR. T. Y. KINNE presented the following resolutions:

"Resolved, that a special committee of three be appointed to consider the change in the publication of the Transactions, and report at the next session of the Institute."

"Resolved, that whenever any Sectional Society desires its Transactions published separately in full, the Publication Committee is authorized so to do at cost price, provided payment for 75 copies is guaranteed."

THE PRESIDENT: The resolutions will be referred to the Committee on Resolutions and take the usual course. The time has now arrived for the meeting of the Section in Neurology, and the Institute stands adjourned.

THIRD DAY

THURSDAY, JUNE NINETEENTH
1902

The third day's meeting of the Institute was called to order at 9:30 a. m. by President Wood.

THE PRESIDENT: The first order of business is the report of the Board of Censors, Dr. Millie J. Chapman, Chairman.

DR. MILLIE J. CHAPMAN: The Board of Censors report favorably on the names presented yesterday morning, with two exceptions, and ask the election of those reported favorably.

DR. WILSON A. SMITH moved that the report be adopted and the applicants named elected. The motion was duly seconded, and carried.

DR. MILLIE J. CHAPMAN: We also recommend for election as corresponding member Dr. E. Monterde, of Mexico City. We have credentials and documents that represent him to be a very desirable member, and we ask his election as corresponding member.

It was moved and duly seconded that Dr. Monterde be elected as corresponding member. Motion carried.

DR. MILLIE J. CHAPMAN, on behalf of the Board of Censors, then presented 21 additional names of applicants.

THE PRESIDENT: The report of the Board of Censors will be received and take the usual course. Next in order of business is the report of the Committee on Revision of the Constitution and By-laws. Dr. T. Y. Kinne, Chairman.

DR. T. Y. KINNE: It is right that we should state some things they have evolved which are not included in the printed report

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you have before you. It is the intention of the Committee, in connection with this report, to present two resolutions to be acted upon by you: *first*, that if the revision prevails, there is to be no change whatever in the manner of conducting business so far as the election of officers is concerned, during this present session; that the tenure of office of those who shall be elected to it, beginning, as heretofore, on the first day of January, 1903, shall cease at the close of the session of that year, excepting as you have already provided. Thus far, the publication of the Transactions will continue during the coming year as it has in the past. There is no desire on the part of the Committee to bring about a radical change which will produce any upheaval or any disarrangement of the standing either of work that has been completed or in process of completion. Thus much by way of explanation. I now call your attention to the point where we stopped yesterday morning, when disposition was made of the Committee's report, as you have it before you. We now begin with Article VI. of the By-laws:

ARTICLE VI.—*Bureaus.*

Section 1.—The following bureaus shall be appointed as hereinafter provided for:

A—Materia Medica and General Therapeutics.

B—Clinical Medicine and Pathology.

C—Pedology.

D—Sanitary Science and Public Health.

I move the adoption of that section as read.

Motion seconded.

DR. H. C. ALLEN: Mr. President, I want to move the addition of another Bureau, a Bureau of Homœopathy, and move that it take a place after "B" Clinical Medicine—"Bureau of Homœopathy." I offer that as an amendment.

Amendment seconded.

DR. J. B. G. CUSTIS: I am very glad Dr. Allen has offered this amendment. We have been told by the friends of this revision that one of the great objects is to give those matters which are distinctive in our school more time than they had under the old *regime*. I do not believe this method will do it to any great extent. We only have now the one day for *Materia Medica and General Therapeutics*. If you put the philosophy of the materia medica and general therapeutics with that, you certainly will not have time to do justice to that distinctive feature which we are promised will be cared for so tenderly. So I shall vote for this amendment.

The question was put on the amendment, and was carried.

THE PRESIDENT: Now, the action reverts back to the original Section as amended.

The question being put, was carried, and the section as amended was adopted.

DR. T. Y. KINNE: The clerical work of renumbering devolves upon the Secretary. Section 2:

"Each of these bureaus shall consist of not less than five members."

I move its adoption.

Motion duly seconded, and carried.

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DR. KINNE: Section 3: The chairman of each bureau, as soon as possible after appointment, shall select his associates and complete the organization of his bureau by the appointment of a secretary. He shall, within one month after his appointment, send to the Secretary a list of the officers and members of his bureau. In case of failure to comply with the provisions of this section, the President is authorized to appoint another chairman. And the Presidents of the Sectional Societies shall also conform to the requirement laid upon the Chairmen of Bureaus, in matter of making report to the Secretary.

I move its adoption.

Motion duly seconded, and carried.

DR. T. Y. KINNE: Section 4. No member shall be appointed to more than one bureau in one year. If any member's name occurs in more than one bureau he shall be notified by the Secretary to elect the one to which he wishes to be assigned. No chairman shall serve as such two successive years.

I move its adoption.

Motion duly seconded, and carried.

DR. T. Y. KINNE: I wish to say one word. The Sections I am now reading are just as they are in the old by-laws under which you have been working so many years. These have not been changed by the Committee on Revision.

Section 5. Vacancies occurring in any section may be filled by the chairman, who shall give immediate notice thereof to the Secretary.

I move its adoption.

Motion duly seconded, and carried.

DR. T. Y. KINNE: Mr. President: I ask for your ruling. Is a failure to vote to be counted in the affirmative?

THE PRESIDENT: The Chair rules that it is necessary to have a vote of two-thirds of the members present.

DR. KINNE then read Section 6, as follows:

Each Sectional Society shall perfect its own organization, make its own constitution and by-laws, elect its own officers and conduct its own deliberations. It shall have self-government, so far as its organization and conduct of its affairs is concerned, but shall be strictly under the rule of the Institute in all matters of publication and other requirements of general welfare.

I move its adoption.

Motion seconded, and carried.

DR. KINNE then read Section 7 of the report, as follows:

The meetings of the Sectional Societies shall be held annually at the same place and time as the Institute, but shall not conflict with the sessions of the Institute except as permitted by the Executive Committee of the Institute.

I move its adoption.

Motion duly seconded, and carried.

DR. KINNE then read Section 8, as follows:

The President of each Sectional Society shall present to the General Session from time to time such matters as may be of general interest to the profession.

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The adoption of the section was moved and duly seconded, and the motion carried.

Section 4 was read by Dr. Kinne, as follows:

Each Sectional Society shall prepare its proceedings for publication and report the same to the Publication Committee of the Institute, within sixty days after adjournment.

Dr. Kinne: I move its adoption.

Dr. J. B. G. Custis: This Section refers to a matter that I wanted to speak on in Section 6, and that is the publication of the reports of the Societies. I do not think that the Institute can by any means publish the reports *in extenso,* especially without making the volume too large and unwieldy; and if the Transactions of the Sectional Societies are to be in the hands of the Publication Committee they are at the mercy of the Institute entirely, and I do not believe the Sectional Societies want that. As far as I know, no Sectional Society has formally asked for this amalgamation process; possibly the Society of Surgeons has, but no other one; and by adopting this they will have to give up their individuality to a greater or less degree, and you will find that will not work well for the Institute, because it will create friction just as soon as this present Committee goes out of existence and you get another. I know this present Publication Committee is all right.

Dr. Ch. Gatchell: I move to amend by substituting in the fourth line "thirty" where it says "sixty."

Dr. Wilson A. Smith: I second the motion.

The motion was carried.

The President: The question reverts to the adoption of the original Section, as amended. Are you ready for the question?

Dr. A. B. Norton: Before this question is put, I would like to say a word in support of Dr. Custis. I do not believe that the Sectional Societies have asked for this, or that they want it; certainly not the Sectional Society with which I am connected, the O. O. and L. Furthermore, as I stated on the floor yesterday, I see no feasible way in which this Institute can publish the Transactions of all these Special Societies without increasing our dues. At the present time, I believe, our Treasurer reports a balance on hand of something near $300. The Transactions of the Special Societies last year covered 385 pages. If somebody can show me how the Institute can publish 385 additional pages of one Sectional Society, and all the others, at an additional expense to the Institute of $300, I will withdraw my opposition, but the only feasible way, it seems to me, that this can be done is by increasing the dues of the American Institute. I, for one, am opposed to increasing the dues. By so doing the tax would fall upon the general practitioner. As the general practitioner now pays but $5, while the specialists are paying $8 and $10, if we increase the dues to $7 to cover this additional expense the general practitioner will be taxed $2 more and the specialists will be cut down $1 and $3 respectively. I do not think it is right to put a tax upon the largest number for the benefit of the few. I propose therefore to offer a substitute to this amendment, the following:

Each Sectional Society shall prepare and publish its own proceedings, as it desires. Copies of the same shall be furnished to the Institute

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membership who are not members of the Sectional Societies at a cost of $1 per volume.

Now, that substitution provides for the specialists having special transactions as they desire them, separate and in distinct volumes where they want them. It provides for the general practitioners who are members of the Institute the privilege of securing these Transactions, if they desire them, for simply $1 extra cost. I move that as a substitute for the report of the committee.

Substitute seconded.

Dr. Ch. Gatchell: Mr. President: I regret to have to take issue with a gentleman of large experience in publication, as I know the last speaker to be. The chief reason that he has urged to you for your support of his amendment is one of dollars and cents. That is always a strong appeal. There are two strong reasons why I think this amendment should not receive your support. One reason, and the chief one, is that every member of the Institute, and more especially every one of those whom we call general practitioners, is entitled to all the work of the Sectional Societies. The general practitioner is the bone and sinew of this Institute. It was founded by the general practitioner, and it should be continued chiefly in his interest. This is the chief reason that I urge upon you not to give your support to this amendment. The other one is a minor one. It is one purely and wholly, as has been advanced, of dollars and cents. I am willing to guarantee that the increased cost of the volume containing these special reports shall not be more than $1, if that much.

Dr. J. B. G. Custis: Mr. President: This does not appeal to me at all, and I think it is likely to mislead the rest of you. We have to consider dollars and cents. If the Institute goes into this you will see who will have to pay the bills, and the only way to pay them will be to increase the dues. I am sorry the doctor did not put his guaranty in a form that we can fall back on. Then we might do as he says.

Dr. Ch. Gatchell: I will do so; I will put it in that form.

Dr. J. B. G. Custis: The Doctor speaks about the Sectional Societies taking away the strength of the Institute. That is just what these amendments will do. Your newspaper here says that the object of the whole thing is that the Institute may be dominated by the Special Societies.

Dr. O. S. Runnels: The paper does not make a correct statement.

Dr. J. B. G. Custis: I hope so, and I think so. I don't follow them at all, but that is the natural impression that is due to this action. The Special Societies tend usually to dominate, so far as I know, but the general practitioner should dominate the Institute and let the specialists take care of themselves where they belong. They live entirely upon the good opinion of the general practitioner. They draw their patients from the general practitioner, and they can do their missionary work better as a special society, spending their own money and sending their literature to the balance of the Institute, than they can if we try to run them. So I think the Doctor is unintentionally misleading.

Dr. O. S. Runnels: Mr. President, this is a very important matter, and no one here has any purpose to rush it along. It needs the

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utmost calm deliberation, and we have not come here this morning to give the final word on this question. In fact, it is not necessary that we should do so, for the reason that for the present year things must go on as they did last year. The special societies have held their meetings and adjourned, and cannot act on anything we do here. Therefore, the proceedings that they now have made are their property, and they will publish their discussions this year as they did last. Now, the Institute will do the same thing. But we ought to be ready for the next year, and we already have before us a resolution that was offered yesterday, whereby a committee of three should be appointed to consider this thing carefully during the next year and bring in a well-digested report upon that matter. Whether we should adopt Dr. Norton's plan (and I am not here to say that it is not the best one and the only one), or some other plan which may appear to be vastly better; or whether the Institute is to publish its own transactions, as Dr. Gatchell suggests, and I am sure if that is feasible we would all be in favor of so doing; or whether it is an absolute necessity that we remand this thing back to the special societies for their treatment, as heretofore, are important questions. For my part, I am not ready to vote on it this morning. I hope we will leave it where it belongs, and go on with our revision, and complete that, and come to the Institute next year well informed as to what is the better course to pursue.

Dr. Bushrod W. James: It seems to me that this matter of paying $1 for the Transactions practically raises the dues to the members of the Institute. Almost every member will want the Transactions of these different societies. If we have four or five of these societies a man pays his dues, $5, and he pays $3 or $4 or $5 for these transactions, and his dues practically become $10.

Dr. B. F. Bailey: I just wish to place before the Institute one or two points that are worth considering in connection with this matter. In the first place, it seems almost an absurdity to the ordinary mind to believe that you can publish the transactions of three great societies at not to exceed $1 additional cost. Secondly, this Institute should not accept the personal guaranty of anybody. We are capable of paying for our own work. We should not ask our Secretary to do any guaranteeing. Thirdly, suppose it costs only $1 a volume more, we publish 2,500 volumes, and that means $2,500. In other words, we must raise our fees if we would pay it, or we would be in debt. Fourthly, this is a matter of vast importance to the Institute, something that we should not act upon hastily, and Mr. Chairman, I move you that action upon this subject be postponed until the next session of the American Institute.

Motion seconded.

Dr. J. B. G. Custis: Mr. President, I rise to a question of privilege. I ask the chair to rule whether the motion which had just been made applies to the Section under consideration, or to the report.

Dr. B. F. Bailey: I simply intended it to refer to this Section under consideration.

The President: It is moved to postpone action on this Section for one year, until the next meeting of the Institute.

Dr. C. B. Sanford: I rise to ask a question. Does that carry with

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it the resolution offered by our chairman yesterday, that a Committee of three be appointed to consider this matter and bring in a fully digested report at the next session?

THE PRESIDENT: I should not think so.

DR. SANFORD: That, however, was referred to the Committee on Resolutions, and they have not offered their report this morning.

THE PRESIDENT: It simply refers to Section 10.

DR. J. B. G. CUSTIS: I want to make an inquiry as to what effect this will have upon Section 5, which says that all matters of publication are in the hands of the Institute. What is going to become of that while we are discussing the other part?

THE PRESIDENT: The resolution which the Chairman of this Committee has before the house I think provides that you go on this year just as formerly, so that it will have no effect.

The motion to postpone was put by the President, but the vote being in doubt, a rising vote was taken, resulting as follows: Aye, 103; no, 72. So the motion was declared carried and the subject postponed.

DR. T. Y. KINNE then continued the reading of the report, as follows: Section 10:

No Constitution or By-law of any Sectional Society shall in any manner conflict with the Constitution or By-laws of the Institute.

I move its adoption.

Motion seconded.

DR. A. B. NORTON: I would like to inquire what authority the Institute has to say what an individual society, not affiliated directly with the Institute, has to do about their by-laws.

DR. O. S. RUNNELS: It is directly under our by-laws.

DR. A. B. NORTON: The Sectional Society has not been organized directly under the Institute. The O., O. and L. Society is closely affiliated with the Institute, but it is a separate institution. It has a membership of 175. We have brought to this meeting probably fifty who would not have been here at all if it had not been for this Society. But at the present time we are not connected with this Institute, and I would like to know by what right this Institute shall say what constitution and by-laws shall govern them.

THE PRESIDENT: Dr. Kinne will explain.

DR. T. Y. KINNE: I will simply say that my neighbor's wife over the way has nothing to do with my family.

The question on the amendment was then put and carried.

DR. KINNE then read as follows: Section 11:

The Institute shall recognize the following Sectional Societies as parts of its body:

(a) The Surgical and Gynecological Society of the American Institute of Homœopathy.

(b) The Ophthalmological, Otological and Laryngological Society of the American Institute of Homœopathy.

(c) The Obstetrical Society of the American Institute of Homœopathy.

(d) The Electro-Therapeutical Society of the American Institute of Homœopathy; and such other Societies as may be formed from time to time, under the rules and regulations of the Institute.

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DR. KINNE: I move its adoption.

Motion seconded.

The motion to adopt Section 11 was put and carried.

DR. KINNE then read Article VII., Section 1, as follows:

ARTICLE VII.—*Committees.*

(a) Organization, Registration, Statistics.
(b) International State Committee.
(c) International Bureau of Homœopathy.
(d) Intercollegiate.
(e) Drug Provings.
(f) Committee on Medical Examining Boards.

It was moved and seconded that the section be adopted.

DR. PEMBERTON DUDLEY: Before leaving Philadelphia the Chairman of the Committee on Pharmacopœia, Dr. Charles Mohr, noted that this Committee, which is a standing committee, was left out of our revision. I was requested to ask that the Committee be reinstated in this new Constitution and By-laws. It is important that our committee on Pharmacopœia should be a standing committee, because there are changes constantly being made, and intelligent pharmacists and materia medicists should have constant charge of that subject, and should keep it in mind all the time, and report to the Institute as they deem fit, and make a complete report to the Institute whenever, in their judgment, there arises the necessity for a new edition of the Pharmacopœia. That is my suggestion.

THE PRESIDENT: Do you make that as a suggestion?

DR. DUDLEY: I think I will leave it to the Committee. I think I have done my duty in the matter.

A motion was made and seconded that the Committee on Pharmacopœia be retained as a standing committee.

DR. A. C. COWPERTHWAITE: I happen to be a member of that committee, and have been since its first organization. The work of that Committee is done for the present. It may be five or ten years before we will require another edition of the pharmacopœia, and it seems to me there will be plenty of time to appoint a special committee for that work, and not burden our by-laws with anything of the kind, or have any extra committees that will have no work to do.

DR. CARMICHAEL: Mr. President, I am also a member of that committee. There is nothing more important than proper attention to the pharmacopœia. In the American Medical Association the United States Pharmacopœia is revised in May of every tenth year. In the past few years it has been revised more frequently. It is absolutely necessary that a proper committee should be a standing committee, before which from time to time matters pertinent to the pharmacopœia may be brought, that they may be properly sifted in order that at certain times the homœopathic pharmacopœia may be revised in a scientific manner. I can see no reason why this committee shall not have a place.

The amendment was then put and carried.

The motion on the adoption of the section as amended was then put and carried.

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DR. J. B. G. CUSTIS: Mr. President, I do not know but it may be provided somewhere else, but how about the committee on medical legislation?

DR. T. Y. KINNE: I will come to that.

DR. J. B. G. CUSTIS: Then the Committee on Legislative Conference; have you provided for that, also?

DR. O. S. RUNNELS: Yes, that all comes in.

DR. T. Y. KINNE: In reply to the question just asked, the committee deemed a Committee on Medical Legislation was unnecessary so long as we have a Committee on Medical Examining Boards. That one committee could do the work which had formerly been assigned to two. The Committee on Education was dropped because we believed the Intercollegiate Committee could do all the work that was necessary and which had formerly been referred to the Committee on Medical Education. That is why you have fewer committees now, under the revision, than you had under your old by-laws.

DR. J. P. SUTHERLAND: I move as an amendment that the title of the Committee under "f" be as follows: "Committee on Medical Examining Boards and Medical Legislation." That would give the power to one committee. It would avoid increasing the number of committees, and yet cover the work proposed by Dr. Custis.

The motion was seconded and carried, and the section as amended was then adopted.

DR. KINNE then read Section 2, of Article VII., as follows:

Committee "B" shall consist of two members from each State, to be appointed by the respective State Societies, provided such appointees are members of the Institute; the Chairman shall be elected by the committee.

Committee "D" shall consist of two delegates to be appointed by each College represented in the Institute, and shall appoint its own Chairman.

Committee "E" shall consist of five members, one to be appointed each year, the term of service of each member of this committee to be five years.

The remaining standing committees shall consist of at least five members each, who shall serve for one year.

DR. KINNE moved the adoption of the Section. Seconded.

DR. A. B. NORTON: I would like to offer an amendment to Section 2, under the head of "Committee B," that it read that the Chairman shall be appointed by the President of the Institute. When this committee was originally formed I believe that was the rule. How it became changed and the committee elected its chairman I do not know. I think it is better to return to the original plan, that the chairman of the Inter-State Committee shall be appointed by the President.

Amendment seconded.

DR. T. Y. KINNE: I have simply this to say, that it is copied from our old by-laws, under which we worked for years.

The amendment was put to a vote and lost. The original section, as read, was then adopted.

Section 3, of Article VII., was then read by Dr. Kinne, as follows:

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There shall also be appointed each year a Committee on Local Arrangements, on Transportation, on Press, on Resolutions and Business, and on the Memorial Service, of not less than three members each. The duties of said Committees shall be such as are indicated by their respective titles. All resolutions presented to the Institute shall be referred without debate to the Committee on Resolutions.

DR. KINNE: I move its adoption.

Motion seconded.

DR. E. B. HOOKER: I move that Section 3 be amended by adding at the end, "except those resolutions emanating from standing committees."

Seconded, and carried. The question to adopt the section as amended was then put and carried.

Section 4 of Article VII. was then read by Dr. Kinne, as follows:

Sec. 4. The President, so far as these By-laws require, shall appoint each of the Committees provided for in this article.

On motion of Dr. Kinne, duly seconded, the section was adopted.

Section 5, of Article VII., was then read, as follows:

All Committees or members appointed to perform any special work under any authority of this Institute shall serve without compensation, unless otherwise specifically ordered.

On motion of Dr. Kinne, duly seconded, the section was adopted.

DR. KINNE then read Section 6, of Article VII., as follows:

The President shall have the power to fill any vacancies that may occur in any committee during or between the sessions of the Institute. Vacancies and elective offices may be filled by nomination and election in open meeting during any session of the Institute, the members-elect to hold such office until the arrival of the regular occupant. The Exexutive Committee may, at any time when deemed necessary, fill any vacancy occurring in an elective office between the session and the opening of the next regular session. Absence from the session of the Institute shall constitute a vacancy.

It was moved and duly seconded that the section be adopted as read. Motion carried and section adopted.

DR. T. Y. KINNE: Mr. President, I ask, in order that business may be expedited, that the entire Article VIII., unless some member wishes to move an amendment, be adopted without the reading, for it is simply a rescript of your old article, "Committee on Publication."

DR. O. S. RUNNELS: I move the adoption of Article VIII. as a whole.

Motion seconded, and carried, and the Article was adopted.

(For Article VIII. the reader is referred to the copy of the Constitution and By-laws in the back part of this VOLUME.)

DR. KINNE: Mr. President, I move that Sections 1, 2, 3, 4, 5, 6 and 7 of Article IX. be adopted without reading, for the same reason as before.

Motion seconded, and carried, and the Sections were adopted.

(The reader is referred to the copy of the Constitution and By-laws in the back part of this VOLUME.)

DR. KINNE then read Section 8, of Article IX.

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It was moved and seconded that the section be adopted as read. Motion carried, and the section declared adopted.

[For Section 8, of Article IX., as adopted, the reader is referred to the copy of the Constitution and By-Laws, in the back part of this VOLUME.]

Section 9, of Article IX., was then read, as follows:

The determination of the next place of meeting shall be made on the second morning of the session, Sundays excepted, at 10 a. m., in the following manner: Nominations shall be made in open Institute and reported to the Executive Committee, who shall investigate and select three which in their judgment are most desirable.

The committee shall, in the month of October following, issue a circular to each member of the Institute descriptive of the various places nominated, together with a return postal addressed to the Secretary, upon which each member shall record his vote. The polls shall be open for thirty days from the date of mailing the circulars. The vote shall be counted by the Executive Committee, and the place receiving the highest number of votes shall be the place for holding the next meeting.

It was moved and seconded that the Section be adopted as read.

DR. PARSONS: I am opposed to that, for the reason that the result of that action will be that the politicians will all go home on the second day. It is entirely too early. I move that the time be fixed as the fourth day of the session.

THE PRESIDENT: That section pertains to the place of meeting. We have already acted upon the voting for officers. That is what the politicians are especially interested in. This is only for the selection of the place of meeting.

DR. A. C. COWPERTHWAITE: I am decidedly opposed to any postal-card vote in the selection of the place of meeting. I do not believe it is right. I move as a substitute that we reject the report of the Committee and leave this as it was in the old by-laws. Let those who come to the American Institute decide where we will meet the next year, and not let the stay-at-homes do the voting.

Motion seconded.

DR. A. B. NORTON: I would like to call the attention of the Institute to the fact that this thing was all thoroughly thrashed out one year ago, that this resolution as it stands was adopted by the American Institute one year ago. It seems to me unwise to reverse the action taken before it has had a fair trial. There is a very strong sentiment in the Institute for giving every member of the Institute an opportunity to vote. The more we extend the hand to the men who are not present the greater the number that we are going to get the next year. The members throughout the country have a right to say where the meeting shall be held. Let the full membership vote. I am opposed to the amendment.

DR. O. S. RUNNELS: For the same reason we have a right to vote for President by postal-card. We say they have no such right. If they want to vote, let them come here.

DR. CH. GATCHELL: Mr. President, I move to amend the amendment by substituting this section, with its proper number:

"The Executive Committee shall select the place for the next meeting of the Institute. The place so selected shall be in a certain region

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of country, which shall be designated by vote of the Institute. This vote shall be taken on the second morning of the session, at 10 a. m., Sundays excepted. The Executive Committee shall report the place selected, through the medical press, by the first day of October following."

Dr. Bushrod W. James: I am opposed to giving the Executive Committee such arduous work to do. I think the members of the Institute are competent to select the place of meeting. There are things that will come up at the Institute meeting which will give us the privilege of going to a certain locality. I think we ought to have the privilege.

Dr. J. B. G. Custis: I am sorry to differ with the speaker again on this subject, but I do not think this matter should be left in the hands of the Executive Committee, except when it is impossible for the Institute to go to the place selected by a majority of the members. There is a very strong feeling on the part of a great many members that we should always go to watering places, with the exception of when you come to Washington, where we can all be under one roof. Certain others believe in the advantages of a city. Let those present decide the question, and not leave it to the Executive Committee, subjected to all sorts of annoyances to influence their opinion at any particular time. I hope we will vote this amendment down.

Dr. Ch. Gatchell: The wording is "*in a certain region of country.*" The Institute certainly should have the right to say whether it will go east, west, north or south, but when it comes to the selection of the particular roof that will be over your head, and the particular surroundings, you cannot come here in this meeting, maybe a thousand miles from the place, and tell, a year in advance, which is just the proper one.

Dr. Norton: One more word. I ask the privilege of speaking one word with reference to the question. I am much pleased, indeed, to see that Dr. Gatchell is of the same opinion that I am, for once. The present amendment offered by the committee places it in the hands of the Executive Committee to practically decide three places for us to select from. Then the Institute votes upon those three, so that the matter is left in the hands of the Executive Committee. All the members of the Institute who have followed its workings year after year know that many meetings we come here without any idea where to go, or the reception we will get, or anything like that. The object of this amendment is that we may vote intelligently. Who knows what place we want to vote for this year? No one. The object of this resolution is not that it shall be put in nomination at this time; that the Executive Committee, of which Dr. Gatchell is a member, shall investigate all the places nominated, whether they be one, ten or twenty, and then they will select three places which they think the most available, and submit them to the vote of the Institute. The selection of three places simply falls in the hands of the committee, and the Institute then votes. The committee are instructed to investigate railroad facilities, the hotel accommodations, the meeting rooms and the hotel-rates and accommodations that we receive, and all these matters are submitted to the Institute, so that you can vote intelligently. The selection of the place of

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meeting is not sprung when one or two doctors can carry it with a hurrah in the Institute in a moment.

DR. T. Y. KINNE: May I give a reason for this work?

THE PRESIDENT: Dr. Kinne.

DR. T. Y. KINNE: The reasons why your committee offered this for your approval, are two. One, that the Institute might know the places to which they are invited. Sometimes promises are made at a session which fail of fulfillment. The recent history of the Institute will show that. The Executive Committee have no power to say where the Institute shall go, but they have power to deliberate, look into the situation, find railroad rates, accommodations, and everything connected with the session of the Institute. By this plan you are not acting in haste to repent at leisure. These are the reasons why the Committee made this as it is.

The question was called for on the amendment, and was put, but, lacking the necessary two thirds vote, it was lost.

THE PRESIDENT: Will you state the amendment, Dr. Cowperthwaite?

DR. A. C. COWPERTHWAITE: The amendment is that matters simply stand as they have been in the past, and that we select in the way we always have, and knock out this postal-card vote. That is what I am opposed to.

THE PRESIDENT: That really is a substitute.

DR. A. C. COWPERTHWAITE: It is that we reject the report of the Committee.

DR. T. Y. KINNE: May I explain? If you pass Dr. Cowperthwaite's amendment you have nothing upon which to work, because you have already stricken out of your by-laws any reference whatever to the determination of the place of meeting.

DR. A. C. COWPERTHWAITE: Let the committee put it in.

DR. JENNEY: I would like to offer a substitute. It is that this committee report at the Institute. Let them meet and do the work three months before the Institute meets, if possible, and then we can vote upon the matter here.

The substitute was ruled out of order.

DR. JENNEY: I offer as a substitute that the original section be substituted for this present resolution.

THE PRESIDENT: The question is already before the house. That is what we are going to vote on.

DR. EUGENE H. PORTER: I want to say just one word regarding the adoption of the scheme. I crave the indulgence of my auditors if I seem to animadvert upon the utterances of those more wise and experienced than I in the management of the affairs of the Institute. But when you entertain a proposition to revert to our old method of adopting a place of meeting, you are doing something that should require, before doing it, serious consideration. Now, Dr. Cowperthwaite, if personalities may be indulged in for a moment, is very desirous of going back to our old plan. That is, we have floods of oratory, fervid, fluent; we have claims of various places presented to us for consideration; then there is a vote taken by the members that are present. Now, the members that are present are not the only members of the Institute. We have a

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large membership. We want to interest them in the Institute, and we want to keep their interest in the Institute. The more we can give them to do, the more we can ask them for their opinion on the best interests of the Institute, and the more they will do for the Institute. The fact that a man does not come to the Institute is no reason why we should not ask him. He pays his five dollars, and there is no reason why he should not have something to say. The postal-card gives every member who pays his dues an opportunity to say where he should like to go to the meeting. We would all like to go to the meeting, but we cannot all go. Some of us are too poor, some have to travel long distances, some are kept away by sickness, some by the exigencies of our business, but we would all like to say where we would like to go for the meeting, because I believe a majority of the members want to go. Before you turn down this postal-card vote, let me say that it has been considered by some of the most experienced members of the Institute, and has been favored as a plan based upon common sense. I ask you to give it serious consideration.

THE PRESIDENT: The question is on the substitute, which is to leave the matter as it is at present, and that we decide on the place of meeting as we have heretofore.

DR. PEMBERTON DUDLEY: If you return to the condition before, you are in a state of chaos.

DR. O. S. RUNNELS: Mr. President, this is an important matter. We have had one instance of a postal-card vote, and that was last year, at Richfield Springs. The year previous the Institute voted to go to Niagara Falls. Postal-cards were sent out, and a vote of 986 was recorded in favor of going to Richfield Springs. How many of those 986 postal-card voters came to Richfield Springs? There were only 200, and I know that more than half of those voted against Richfield Springs. I tell you the postal-card vote does not mean a vote representing the people who want to go to the Institute. Members who attend the Institute ought to go where they want to go, and I want them to understand that they must come here if they want to vote. I move as an amendment that all applications, or all invitations for places of meeting be forwarded to the Executive Committee at least ninety days before the session, and that the Committee be empowered and instructed to canvass the desirability of the various places, and hotel-rates and all information necessary, and come here and inform this body what is the best thing to do, and report what we ought to do, and we will vote upon it here. That is my amendment.

Amendment seconded.

DR. A. C. COWPERTHWAITE: I would like, with the consent of my second, to withdraw my amendment and let the amendment of Dr. Runnels stand as the original amendment.

DR. G. FORREST MARTIN: I wish to speak to the amendment offered by Dr. Runnels. The objections which Dr. Runnels has raised to the postal-card vote are not in any sense stated in a thorough manner. The instance of a vote by postal-card which Dr. Runnels stated here, was a vote, not upon where we should meet, but a vote upon which of the places. The two conditions are not parallel. In regard to voting upon the place of meeting, that is one that should be extended to every member of this

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Institute, whether they are able to be present at the place chosen or not. This is a society which we desire to popularize. We want all homœopaths in this society, and if we would win them we must give them every possible opportunity to have a voice in its proceedings. Now, it is all very well to say that only those who come to the meeting shall have a voice in the selection of the place of meeting, but I call the attention of the members to the fact that every meeting, no matter where held, is more or less dominated by local influences. Take this meeting here to-day, it is a meeting made up in the vast majority of men within easy reach of Cleveland. And it is the same everywhere. The majority are necessarily influenced by the locality, and the majority can decide the place for the future meeting, if they see fit. Every member of this Institute should have a voice in the proceedings, and it is well provided for in the section.

Dr. T. Y. Kinne: I wish to explain. The Committee have no choice as to whether the original amendment, or its amendment, shall pass. It is the difference between *post hoc* and *propter hoc*.

The question was then put on Dr. Runnels' amendment, and the chair was in doubt as to the result. A rising vote being taken, the amendment was declared carried.

The original motion, as amended, was then put and carried.

Dr. T. Y. Kinne: Mr. President, I move that Article X. of the amendments to the By-laws, and Article XI., and the standing resolutions, be acted upon without reading, for Article X. and XI. are precisely the same as in our former By-laws. We have simply cut out of the standing resolutions those that have been inoperative through other action of the Institute. I ask that they be passed.

Motion seconded and carried.

(For Articles X. and XI., the Standing Resolutions, as adopted, see copy of the Constitution and By-laws in the back part of this Volume.)

Dr. T. Y. Kinne: I now move the adoption of the report of the Committee as a whole.

Motion seconded and carried.

The Board of Censors reported 18 names of new applicants for membership.

The President: The report of the Board of Censors will take the usual course.

It was moved and seconded that the By-Laws be suspended and that the time given to members to vote for officers be extended until one o'clock p. m., to-day.

Motion seconded and carried.

The meeting of the Institute was then declared adjourned.

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FOURTH DAY

FRIDAY, JUNE TWENTIETH
1902

The fourth day's meeting of the Institute opened at 9:30 a. m., President Wood in the chair.

The Board of Censors, by Millie J. Chapman, Chairman, presented the names of eight applicants for membership, and the report was referred to take the usual course.

DR. MILLIE J. CHAPMAN: The names that I read yesterday morning the Board of Censors have reported favorably upon, and I ask the election of the applicants.

It was moved and duly seconded and the Secretary cast the ballot of the Institute for the applicants referred to. Motion carried, and the applicants were declared elected members.

DR. T. Y. KINNE: Mr. President, I wish to present a supplementary report from the Committee on Revision of the Constitution and By-Laws in compliance with the statement made yesterday morning:

"Wherever changes relating to business occurs, this revision shall go into effect January 1, 1903. Changes as to officers shall become operative at the close of the session in 1903."

According to this, the new revised constitution and by-laws go into effect gradually. They have no influence whatever upon the work of the officers of this year; they are working under the old constitution and by-laws. It simply takes up the work of the future, and the Executive Committee now in office govern their movements and appointments according to the lists made out in the revised By-Laws.

It was moved and seconded that the supplementary report be adopted. Motion carried.

DR. T. Y. KINNE: We are finite, all liable to mistakes. The Committee on Revision noted one omission, which it is now too late to insert this year. I therefore give notice that next year I shall move an amendment to the By-laws, Article IX., Section 7, to read as follows:

"In all elections before this Institute a majority of votes shall be necessary to a choice."

THE PRESIDENT: I would like to ask Dr. Kinne, how does this affect the election of Recording Secretary, whose name was on the ballots in this election?

DR. KINNE: It makes no change whatever in any officers that are to be elected at this session.

THE PRESIDENT: Next in order will be the Report of the Committee on Elections, Dr. C. B. Kinyon, Chairman.

DR. C. B. KINYON: The Committee on Elections beg leave to make the following report:

The total number of votes cast was 319.

Necessary to a choice, 160.

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Of these votes the following candidates received the following number:

For President, Joseph P. Cobb, 113; William H. Hanchett, 111; Dr. Edward Beecher Hooker, 89.

For Vice-President, H. F. Biggar, 196; James W. Ward, 119.

For Second Vice-President, M. Belle Brown, 279.

For Secretary, Charles Gatchell, 191; Frank Kraft, 121.

For Recording Secretary, J. Richey Horner, 271.

For Treasurer, T. Franklin Smith, 288.

For Registrar, Henry C. Aldrich, 281.

For Censor, Millie J. Chapman, 279.

For Necrologist, C. A. Weirick, 278.

All of which is respectfully submitted.

THE PRESIDENT: The Chair declares elected: Dr. H. F. Biggar, Vice-President; Dr. M. Belle Brown, Second Vice-President; Dr. Charles Gatchell, Secretary; Dr. J. Richey Horner, Recording Secretary; Dr. T. Franklin Smith, Treasurer; Dr. Henry C. Aldrich, Registrar; Dr. Millie J. Chapman, Censor; and Dr. C. A. Weirick, Necrologist. The Chair also decides that there has been no choice in the election of a President. What is your wish in this matter? According to the By-laws we must decide by open ballot. Shall it be a ballot by the Australian system, or shall it be an ordinary ballot?

DR. A. B. NORTON: I move that we suspend the portion of the By-Laws regarding the election of officers in open session, and that the election take place in the adjoining room from 10 to 12.

Motion seconded and carried.

DR. A. B. NORTON: I move that election take place from 10 to 12, according to the Australian system.

Motion seconded, and carried.

THE PRESIDENT: Next in order of business this morning is the selection of a place of meeting for next year.

DR. A. B. NORTON: I think it is in order to nominate as many places as a person desires. As many of the members of the Institute know, I have for quite a number of years, openly on the floor of the meetings, opposed the selection of cities, and in order to have a sufficien- number of resorts from all parts of the country to present to this body for consideration, I had, through a friend in the American Express Company, a communication opened with all the main lines in this country, asking them a series of questions as to resorts on their lines, railroad facilities, hotel accommodations, etc. I received quite a volume of correspondence, and have selected from the letters a few places that I shall nominate as places of meeting for next year.

Dr. Norton then read the correspondence on the subject, and afterwards put in nomination Saratoga Springs; Alexandria Bay; Put-in-Bay; Lakewood Hotel, Chautauqua; White Sulphur Springs, W. Va.; Hotel Rider, Cambridge Springs, Pa.; Mountain Lake Park Association, and Bedford Springs, Va.

J. HERBERT MOORE: Mr. President, and members of the Institute: Realizing that thirty-four years will have elapsed next June since the last meeting of the American Institute in Boston, and realizing that

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there has been a spontaneous desire on the part of many members from different parts of the country to go to Boston this year, the Boston Homœopathic Society at its last meeting unanimously voted to extend to the American Institute a most cordial invitation to meet in Boston or vicinity next year. A week later the Massachusetts Surgical and Gynecological Society, another and a very flourishing organization, voted to unite with the Boston Homœopathic Society in extending this invitation, and they appointed a committee, with full powers, to present this invitation to the Institute, and it is with great pleasure that it makes its report this morning. The committee comes to the Institute this morning amply prepared to assure the Institute that they will be most satisfactorily accommodated, whether they meet in the city of Boston or whether they meet outside. We have two plans: first, to meet at the western extremity of our city, practically within the city, on the border of our parkway, at our new and popular "Hotel Somerset. Here we have most ample accommodations for the members of the Institute. On the other hand, if the members of the institute insist on going to salt water, we can also accommodate you at Nantasket Beach. Nantasket Beach is 55 minutes' boat-ride from the city of Boston, through our beautiful Boston harbor, and we have full hotel accommodations.

Now, members of the Institute, we very much desire that you come to Boston. We also very much desire, in order that the majority of this Institute may be perfectly happy, that through your Executive Committee, or in any other way that you choose, you select the place to meet, whether it shall be Boston or Nantasket Beach, and we assure you that whether you meet in the city or at the Beach you will not regret coming to Boston next year.

Dr. J. P. Sutherland: Mr. President and Members of the Institute. I think it is unnecessary to add anything to what Dr. Moore has said. There is such a town as Boston, and we certainly have facilities enough for the accommodation of the Institute. It is a long time since the Institute visited Boston, and you may be assured of a very hearty welcome. We ask you to come.

Dr. C. E. Walton: As a matter of courtesy, I want to put in nomination Milwaukee, because the Chamber of Commerce of that city has sent out invitations for our meeting.

Dr. M. A. Barndt: I wish to second Dr. Walton's nomination by reading a few letters that I have received, as I am a resident of the city named.

Dr. Barndt read letters from the Milwaukee Citizens' Business Association, and from the Mayor of Milwaukee.

Dr. O. S. Runnels: I move that the American Institute select Boston as its next place of meeting.

Motion seconded.

Dr. Edward Beecher Hooker: If Dr. Runnels will permit me, I would like to offer a slight amendment. I move that the session of the American Institute of Homœopathy for 1903 be held in Boston or its immediate vicinity, the exact location to be decided by the incoming Executive Committee.

Dr. Runnels: I accept the amendment.

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DR. T. Y. KINNE: Mr. President and members, let me call your attention to your action last year, and before you decide to do, what I so devoutly trust may be done, let us do it so that it shall conform to previous action. (Reading from the Volume of Transactions of 1901):

"That the different localities be nominated as provided for, and, at the close of the session, referred to the Executive Committee, who shall, through correspondence or information received from those who know the eligibility of the different places, select the most suitable. If more than three are named, they shall select the three which in their judgment are best entitled to choice. Then, in the month of October, they shall send out for a postal-card vote from all the members of the Institute, whose will shall decide the place of meeting for the ensuing year." After discussion and amendment it was carried. I move you, sir, therefore, that the places already put in nomination and those which shall hereafter be put in nomination, be referred to your Executive Committee for action, as your resolution of last year provides.

DR. C. E. WALTON: I move to suspend that resolution and proceed to the selection of a place of meeting.

THE PRESIDENT: Dr. Walton moves to suspend the resolution and proceed to the selection of the place of meeting.

The motion to suspend the rules was put and declared carried by a two-thirds vote.

DR. O. S. RUNNELS: I now renew my motion to go to Boston or its environments. I accept Dr. Hooker's amendment.

DR. E. B. HOOKER: I will read the motion which Dr. Runnels and I have made in conjunction. I move that the session of the American Institute of Homœopathy for 1903 be held in Boston or its immediate vicinity, the exact location to be decided by the incoming Executive Committee.

DR. J. HERBERT MOORE: As chairman of the committee on invitation from the Boston Homœopathic Society, I second the motion of Dr. Hooker.

The motion was then put and carried.

DR. J. B. GARRISON: The Committee on Medical Examining Boards presents the following report:

Meetings of the National Association of Homœopathic Members of Examining and Licensing Boards were held on June 18 and 20, 1901, at which papers were presented, the list embracing, among others, the following:

An address by Dr. A. Korndoerfer, of Philadelphia, President of the Association.

A statement by Dr. J. H. Crowell, of Saginaw, Mich., describing the measures inaugurated and being carried on by representatives of examining boards in the states of Michigan, Illinois, Indiana, Ohio and others, looking to the establishment of reciprocity in the recognition of license to enter on the practice of medicine.

Dr. B. F. Bailey, of Lincoln, Neb., outlined a plan for establishing approximate uniformity of the standards of medical learning in all the States.

Papers were also presented, and the discussions thereon were participated in by Dr. J. B. G. Custis, of Washington, D. C.; Dr. H. E. Beebe,

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of Sidney, Ohio; Dr. J. M. Lee, of Rochester, N. Y.; Dr. H. F. Cole, of Hartford, Conn.; Dr. C. E. Sanford, of Bridgeport, Conn.; Dr. W. O. Forbes, of Chicago, Ill.; Dr. H. M. Paine, of Atlanta, Ga., and others.

The subjects presented for consideration related mainly to the advancement that is being made throughout the country for attaining uniform educational standards on which interstate reciprocity in the recognition of the state license can be secured.

Very satisfactory progress in a number of states was reported, and the belief was expressed that as no satisfactory or feasible form of national supervision had been devised, relief from present defects was to be sought and secured, state by state, through the united action of the examining boards themselves.

The officers elected for the ensuing year are:

President—Dr. A. Korndoerfer, Philadelphia, Penn.

Secretary—Dr. H. M. Paine, Atlanta, Ga.

Treasurer—Dr. Geo. D. Streeter, Waco, Texas.

Executive Committee—The President, Secretary, Treasurer, and Dr. S. H. Calderwood, Boston, Mass., and Dr. J. H. Cowell, Saginaw, Michigan.

Dr. B. W. James moved that the report be referred to the Committee on Publication.

Motion seconded and carried.

THE PRESIDENT: Next in order of business is the report of the Commtttee on Medical Education.

DR. A. C. COWPERTHWAITE: I wish to make an explanation. In the first place, I am Chairman of the Committee. In the next place, the whole committee was left out of the Transactions, and I did not know until last week that I was Chairman, so that no report has been prepared.

THE PRESIDENT: Next is the report of the Hahnemann Monument Committee.

DR. J. H. MCCLELLAND: Mr. President, the report of the Hahnemann Monument Committee is very brief. I simply wish to add that the book giving a history of the monument and its dedication is now in the hands of the printer and will be delivered to the subscribers within a very few weeks. Otherwise, the monument is finished, and also the work of the committee.

On motion, duly seconded, the report was received and referred to the Committee on Resolutions.

DR. J. G. B. CUSTIS: The Auditing Committee reports that it has examined the accounts of the Treasurer and found them correct, and have so marked them on the books.

On motion, the report was received and concurred in.

Reports of the Committee on Medical Literature, the Interstate Committee, Committee on Life Insurance Examinations, Press Committee, Committee on Organization, Registration and Statistics, and Committee on President's Address, were called for, but there being no response, they were passed.

THE PRESIDENT: Next is the report of the Intercollegiate Committee, Dr. H. M. Dearborn, Chairman.

Dr. H. M. Dearborn then read the report of the Intercollegiate Committee, as follows:

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RESOLVED, That the teaching of the principles of homœopathy, as enunciated in *Organon, homoeopathic pharmaceutics* and the *homoeopathic materia medica,* be continued throughout the entire four years' course. The *Organon and homoeopathic pharmaceutics* at least one year, and the *homoeopathic materia medica* at least three years.

RESOLVED, That the clinical teaching in our schools should be brought into the greatest attainable harmony with the teaching of *materia medica.*

RESOLVED, That we disapprove of and discountenance all teachings which give approval to what is known as the purely empirical use of medicines, for the use of proprietary medicines and combination-tablets, believing that such teaching is productive of confusion in the minds of students, subversive of the principles of hoœopathy, and that it tends to retard true progress in the establishment of a scientific materia medica and therapeutics.

RESOLVED, That each College represented in the Intercollegiate Committee be required to furnish annually to the Secretary of said Committee, before the opening of its session, a copy of its last announcement, and to report to the same officer within ten days after Commencement, on a blank form to be furnished by the Institute, the names of its new graduates, the time each one spent in college work in separate years, and the names of the Institutions attended in the several years or periods of study.

DR. H. M. DEARBORN: These resolutions the Committee presents to the Institute for adoption as standing resolutions. The committee will have a further report to make on some matters at the session to-morrow.

It was moved and seconded that the report be received and referred to the Committee on Resolutions. Motion carried.

THE PRESIDENT: Report of the Committee on Resolutions.

DR. J. B. G. CUSTIS: Dr. B. F. Bailey, Chairman, handed me the resolutions. He had only two, one of which is covered by the action of yesterday, and our recommendation is that it be laid on the table. I will read that first:

"Resolved, That whenever any Sectional Society desires its transactions published separately in full, the Publication Committee is authorized so to do at cost price, provided the payment for seventy-five copies is guaranteed."

On motion of Dr. A. C. Cowperthwaite, duly seconded, it was voted to adopt the report of the committee.

DR. J. B. G. CUSTIS: I have the other resolution:

"Resolved, That a special committee of three be appointed to consider changes in the publication of the Transactions, and report at the next session of the Institute."

DR. B. W. JAMES: I move that we receive the report of the Committee on Resolutions.

Motion seconded, and carried.

THE PRESIDENT: That does not adopt the resolution.

The motion to receive and adopt was then made, seconded, and carried.

DR. J. B. G. CUSTIS: Mr. President, the Committee on Resolu-

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tions report back the resolutions just read by the Chairman of the Intercollegiate Committee, with their approval. This we consider the best set of resolutions, and the most valuable, ever presented before this body, and we recommend their adoption.

Motion seconded, and resolutions adopted.

THE PRESIDENT: Dr. W. A. Dewey will now read the report on the Co-operation of the O., O. and L. Society in Test-Proving.

Dr. W. A. Dewey made the following report:

The money placed at the disposal of the Committee by the American Institute is being used by the Committee and the O., O. and L. Society as needed for the purpose of meeting the general expenses of the meeting, especially for the preparation of the examiners' forms, which are referred to in the report which was made to the O., O. and L. Society by the Chairman, Dr. Bellows. Every dollar thus raised by the various boards in different cities is thus left wholly at their disposal, and can be applied directly to the payment of provers; therefore, all that we have to report is progress. The provings are under way in various cities, and it is a work that cannot be done in one year, as you all know, and therefore we can only report progress and explain where the money has gone to that was donated by the Institute to the Committee.

DR. E. B. HOOKER: I move that the report be accepted, with thanks. This committee on drug-proving is doing a very excellent work, and the Institute should be grateful to these gentlemen who have undertaken in a small way, but which will become ultimately a large way, a very great work. I move that the report be adopted and the Committee continued.

Motion seconded, and carried.

DR. T. Y. KINNE: Mr. President, I stand before you as the representative of the widow of our lamented friend, the late Dr. Selden H. Talcott. She received your telegram of condolence and sympathy with profound esteem. She feels that in her sorrow you have a part, and she wishes me to say to you that from her heart she thanks you for what you have said to her, and that all through her life she shall remember with lively feelings the interest you have had in her, through her husband. In connection with this, I desire to report, on behalf of the committee on Memorial Service, which service is to be held this evening in this place, that brief addresses, interspersed with music, will be given by Drs. J. C. Sanders, H. F. Biggar, Julia Holmes Smith and A. C. Cowperthwaite, and, sir, with your permission, I will call for the report of the Necrologist, which comes in with this.

DR. A. C. COWPERTHWAITE: I beg leave to present the list, containing the names of those who have died during the past year. Dr. Elias C. Price, of Baltimore, has died during the session of this Institute, and his funeral is taking place to-day. I would suggest that as we have established a precedent, and as Dr. Price was one of our Seniors, a telegram of condolence be sent to his family to-day.

(For the list of deceased members see page 88.)

Motion seconded and unanimously carried.

The Board of Censors, through Dr. Millie J. Chapman, reported six applications for membership.

THE PRESIDENT: The report of the Board of Censors will be received and take the usual course.

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DR. C. B. GILBERT: I desire to give notice of a proposed amendment to the Constitution, to Article I., Section 2:

"Homœopathy is declared to be a system of medicine founded upon natural law, and the only system so founded. This law is set forth specifically in Sections 25, 26 and 27 of the Organon of Samuel Hahnemann, fifth edition, and is known as the law of similars, which is expressed by the formula, 'similia similibus curantur.'

"Article IV. Strike out the words 'an inscription' and substitute the words 'and with an inscription which shall be' 'similia similibus curantur,' so that as printed the section shall read:

"The Institute shall have and use one common seal with a suitable device and with an inscription which shall be 'similia similibus curantur.'"

THE PRESIDENT: The notice will be received and take the usual course.

The report of the Committee on Medical Literature, Dr. Frank Kraft, Chairman, was called for.

Dr. Frank Kraft submitted the following report:

I find that only two homœopathic firms have issued any new books, to which I have access,—namely the Boericke & Tafel Company, and the Era Publishing Company, the books being as follows—first by B. & T.:

THE THERAPEUTICS OF FEVERS; Continued, Bilious, Intermittent, Malarial Remittent, Pernicious, Typhoid, Typhus, Septic, Yellow, Zymotic, etc. By H. C. ALLEN, M. D., 1902.

DISEASES AND THERAPEUTICS OF THE SKIN; By J. HENRY ALLEN, M. D. 1902.

ORGANON OF MEDICINE. By SAMUEL HAHNEMANN. *Aude sapere.* Translated from the Fifth Edition, with an appendix, by R. E. DUDGEON, M. D. Authorized American Edition. 1901.

OPHTHALMIC DISEASES AND THERAPEUTICS. By A. B. NORTON, M. D. With Ninety Illustrations and Eighteen Chromo-Lithographic Figures. Third Edition. Revised and Enlarged. 1902.

CATS. How to Care for Them in Health and Treat Them in Disease. By EDITH K. NEEL. 48 pages. 1902.

LEADERS IN HOMOEOPATHIC THERAPEUTICS; By E. B. NASH, M. D. Revised and Enlarged. 420 pages. 1901.

PRACTICAL MEDICINE; By F. MORTIMER LAWRENCE, M. D. 521 pages. 1901.

HAY FEVER AND CATARRH OF HEAD AND NOSE. With their Preventive and Curative Treatment. By E. B. FANNING, M. D. 170 pages. 1901.

REGIONAL LEADERS; By E. B. NASH, M. D. 282 pages. 1901.

And the publication of the new book by our talented and energetic Secretary, Dr. Charles Gatchell, entitled: *Diseases of the Lungs; Their Pathology, Symptomatology, Diagnosis and Treatment.* Dr. Gatchell's fame as a writer of interesting and valuable books is established of old, and rests upon a secure foundation. It needs nothing that this Committee can give. This latest book from Dr. Gatchell's pen, complete and perfect in every detail, lies before you.

In passing, I wish to call attention to the new edition of the *Homoeopathic Pharmacopoeia of the United States,* from the press of Otis

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Clapp & Son, with the first edition of which the homœopathic profession is familiar. No comments are called for from your Chairman touching the value of these faithful efforts of your membership to unify the labors of the homœopathic pharmacies. Their value must be apparent. That a strict following may for a time cause some confusion, is granted, as follow necessarily upon all changes from an old and established custom; but, in the end, unanimity of pharmaceutical formulæ will obtain and that seems to be the prime purpose of the work.

It may not be inappropriate to call especial attention, in a line or two, to the new edition of our former President, Dr. A. B. Norton's *Ophthalmic Diseases and Therapeutics.* Being now in its Third Edition, Enlarged and Improved, and brought down to the instant moment of its publication, its merits have been conceded. Success is a pretty safe criterion of worth. The other book is by Dr. H. C. Allen of Chicago, Editor of the *Medical Advance,* the present book being shorn of part of its former title—this being a new and revised edition—and now called *The Therapeutics of Fever.* Every member of this Institute knows H. C. Allen, and knows what his name stands for on the title-page of a book or journal.

In England, Dr. John H. Clarke, the versatile and hard-working editor of the (London) *Homoepathic World,* has finished his *Dictionary of Medicine,* and the completed volumes, with all their evidence of labor, and wealth of material, are now in the hands of our profession.

In the domain of journalism, I find that all the journals of last year continue in existence, several of them enlarged and made beautiful with new covers; others have changed the editorial department by adding newer men of the tripod. Two of the journals have changed their titles: *The American Homoeopathist* to that of *The American Physician,* and the *Cleveland Reporter,* formerly a mere college echo, to *The Cleveland Medical and Surgical Reporter,* much enlarged and reaching out after cosmopolitan journalistic honors.

One new journal has appeared: *The Homoeopathic Journal of Pediatrics,* with its home in Buffalo, and its editorial department in charge of Dr. J. G. Chadwick, of that city, who wields a bright, entertaining and instructive pen, and who is, as all good homœopaths are, a member of the American Institute of Homœopathy.

I hear that the son of that Prince of Materia Medica, Farrington, has purchased the *Journal of Homoeopathics* and becomes its editor. May the distinguished talent of his lamented, but not forgotten father, descend upon his son, with almost an embarrassment of riches, and, thus, once more, fill the homœopathic world with good, pure, homœopathy—like his Father used to Teach.

FRANK KRAFT, *Chairman.*

THE PRESIDENT: Is there anything further under the head of new business?

THE PRESIDENT: The Chair will state that we have now 155 applications for membership.

DR. J. H. MCCLELLAND, from the Committee on Medical Legislation: I was not aware that I was Chairman of that committee. I simply report that there are various items of legislation in progress in the city

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of Washington, particularly that of the Pure-Food Bill, which probably will not pass. It is not satisfactory. Aside from that there is no general measure before Congress at present. Therefore the Committee has no definite report to make.

Moved that the report be received and referred.

Motion seconded and carried.

The meeting was then declared adjourned.

MEMORIAL SERVICES

EVENING

President J. C. Wood in calling the meeting to order said:

Before turning this meeting over to the Presiding Officer of the evening I desire to state that the widow of the late Dr. A. I. Sawyer, my former preceptor and very dear friend—than whom no better or godlier man ever lived—has for two years been totally blind, bearing her affliction with the greatest fortitude, cheerfully, willingly and always bright and happy. This sweet woman has been shut in her room during this time unable to leave it. I feel that it would be proper and right to remember the living as well as the dead. I therefore propose, with the permission of the Chairman of this meeting and the members of the Institute, to send her the following telegram:

"Mrs. A. I. Sawyer Monroe, Mich.:

"The American Institute of Homœopathy, assembled in Memorial Service, not forgetful of your distinguished husband, extends to you a heartfelt sympathy in your sad affliction."

It is now my pleasure and my privilege to turn this meeting over to Dr. Theodore Y. Kinne, Chairman of the Committee on Memorial Services. Dr. Kinne.

Dr. T. Y. Kinne: We will now join in an invocation to Almighty God, offered by Rev. Ward Beecher Pickard, D. D., pastor of Epworth Memorial Church.

The Rev. Ward Beecher Pickard: Let us pray. Almighty God, our Heavenly Father, we thank Thee that we may feel the utmost assurance in asking Thy blessings upon us as we are gathered here to-night. It is a blessed privilege to know Thy relations to the welfare of Thy children, for as a mother comforteth her children, so the Lord, in tender mercy, ministereth to His. Like as a father pitieth his children so the Lord pitieth them that fear Him. For He knoweth our frame, He remembereth that we are dust. We come with confidence, therefore, in asking Thee to appease Thy wrath while we unite in remembering the faces of those gone before, and who, while living, were among those who loved us and among those we loved.

Thy favor is upon us, and we, Thy children, would come before Thee beseeching that pity and help which cometh only from the Lord, and to implore Thee that the rich blessings of Heaven may fall upon our hearts, as falleth the dew upon the flowers. We thank Thee, our Father, for all these great ideas into which men have given expression, for the comforts and improvements which have followed; these are but

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the expression of Thine own thought. We thank Thee that men are learning to speak with God; that what was written is being fulfilled in these great strides whereby the laws of health are being more clearly brought out; we believe Thy kingdom will come, and Thy will is being done, and our prayers are being answered in the revealed facts, in the clear understanding and in the marvelous progress which science in the name of God, is giving to Thy people.

Be with us as we remember those brave men and women who have passed into the higher life, and as we are gathered here to honor their names and to give them credit for the labors which they have performed, may we, who live, posses that higher conception of life through a better knowledge of Thee, climb upward unto nobler heights and grander thoughts Guide us in all our deliberations, and we implore Thee to be Thou with them until they meet again. Asking it all in the name of the Master. Amen.

T. Y. KINNE, M. D.: Miss Effie Stewart will render for us "There is a Green Hill Far Away."

Miss Stewart rendered the song most beautifully.

CHAIRMAN: We will now listen to the report of the Necrologist, Dr. Cowperthwaite.

DR. A. C. COWPERTHWAITE: The following named members of the Institute have died during the past year:

Andrews, Sarah W., Chicago, Ills.;
Boericke, Francis, Philadelphia, Pa.;
Bonnell, Charles L., Brooklyn, N. Y.;
Boothby, Alonzo, Boston, Mass.;
Burgher, John C., Pittsburg, Pa.;
Couden, Wm. C., Denver, Colo.;
Downey, F. E., Clinton, Ills.;
Duncan, James C., De Kalb, Ills.;
Fisher, Edward A., Buffalo, N. Y.;
French, Hayes C., San Francisco, Cal.;
Gann, John A., Wooster, Ohio;
Goodman, Julia, Hamilton, Ohio;
Gramm, Gustavus E., Ardmore, Pa.;
Griffith, Anna E., Camden, N. J.;
Haynes, John R., Indianapolis, Ind.;
Houghton, Henry C., New York, N. Y.;
Hughes, Richard, Brighton, England;
Kirkpatrick, John C., Los Angeles, Cal.;
Pinkham, Chas. B., San Francisco, Calif.
Price Elias C., Baltimore, Md.;
Pulver, Hudson, J., Torrington, Conn.;
Schmucker, Francis, R., Reading, Pa.;
Shepard, Jessie, Buffalo, N. Y.;
Shivers, Bowman N., Haddonfield, N. J.;
Smith, Sarah, Council Bluffs, Iowa;
Talcott Selden H., Middletown, N. Y.;
Talmage, Alonzo L., Waterloo, N. Y.;
Von Gottschalk, Wm., Central Falls, Conn.;
Wilson, Grove H., Meriden, Conn.

CHAIRMAN: We will now be addressed by Dr. J. C. Sanders, of Cleveland.

ADDRESS BY DR. JOHN C. SANDERS.

There is not a function in life's experience that carries a greater depth and tenderness of solemnity than this one of paying public tribute to the dead whom we have revered or loved, and would thereby honor. Words seem powerless fittingly to express what our hearts would tell, and in telling may leave it still unsaid in part, or say it in too great excess.

Though it is appointed unto man to die, it is a popularly expressed surprise and wonder why death, except from unavoidable accident or the normal infirmity of years, should befall a medical man. His very pupilage for his profession is a study of disease, a study of all its varied and subtle causes, its versatile phenomena of development and progression and of its varied and multiplied means of relief and cure; and after entering the profession his still more interested study is in the same channel, only widened and deepened and enriched by the garnered

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wisdom of the world's best experience. This broadened knowledge and wisdom most naturally warrant wonderment and surprise, why a physician, save from accident or infirmity of years, should not so anticipate and avert the approaches of disease as virtually to become immune, and thereby be able to keep his health unimpaired, even to the limit of one's allotted years. The people at large, educated or not, not infrequently express surprise when their physician is reported sick or disabled, and in some such form as this: "Why should a doctor get sick? He, above all men, should be able to keep in health!" And in case their doctor's illness proves fatal, their wonderment will sometimes take the taunt of those who crucified our Lord: "He saved others, Himself He cannot save."

It is doubtless true that the physician of liberal and broad culture, and who possesses a healthful heredity, would rarely or never sicken, or become prematurely the victim of the decrepitude of age, could he or would he live chiefly or solely for himself, and prosecute his profession as a sort of past-time or recreation, avoiding its cares and anxieties and shrinking from its toils and responsibilities. But if his soul is fired with the high and holy inspiration of his callng, this he cannot do and will not do. He recognizes that his mission is to minister to the sick and suffering, by night or by day, in storm or in shine, in strength or in weariness of body and mind, to relieve pain, to stay the march of disease, to calm fears, to soothe anxieties, to inspire courage and faith, to do all within his power to save from death; and when death presses on as inevitable, to soften and smooth the way to its portal of oblivion. These extremities of disease and danger and these adverse results which will, at times, befall his ministry despite his greatest skill and most devoted attention, make mighty draughts upon his powers of body and spirit, pleading as they do for succor and relief, and in case of failure, challenging as they do the deepest and tenderest of his sympathies and condolence.

This exalted mission carries him into the palaces of the rich and into the hovels of the poor, among the high and among the lowly, into homes of ideal sanitation and into homes rank with infection. He shrinks not from confronting pestilential scourge or epidemic peril. He must often assume and bear responsibilities that shake his very soul with dread over the impending danger to the precious life or lives committed to his skill. His entire professional life is an unceasing conflict with disease and suffering, with danger and with death. His career is altruistic in the highest possible degree. He lives not for himself, but for those whom he serves, and these he serves with the best of his powers of body, mind and soul.

What wonder then is it that the physician should early fall by the wayside? What wonder then is the startling record of mortality that annually sweeps over the membership of the American Institute? What wonder then that since the Institute's last session at Richfield Springs in June, 1901, twenty-nine of its membership, eleven of whom were seniors, have laid them down in their last sleep, where the new blade of the spring grass, the opening bud of shrub and tree, the violet's cup of dew, the bluebird's matin song, the insect's noonday hymn and the robin's vesper chant, will be the requiem, and the annual recurring

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requiem, with which kind nature will requite the sacred trust committed to her keeping!

Death is the most momentous event incident to our earthly state. Its significance is tremendous to the subject of it, and may be hardly less so to all who are directly affected by it. The death of a true physician in its resultant effects upon the communities wherein has rested his sphere of influence and ministry is more and peculiarly impressive than the death of a corresponding representative of any other calling in life. This is true, because his professional life brings him nearer to the homes and hearts of those whom he serves than is possible to the ministry of any other profession. He is admitted to the inner sanctuary, the holy of holies of every household committed to his charge. He is made the custodian of confidences which would not dare be breathed upon any other ear. He is the family's tower of strength, and hope of safety in the hours of direst need. How eagerly and anxiously his coming is often looked for; how assuring and comforting his presence often is; how often his every look and word and tone are watched and listened to with bated breath and aching heart! His fatherhood of loving care fails not to reach and encompass the children of these households; he presides at their birth, and his tender and sympathetic ministry he continues towards them when they are in sickness and suffering. How fondly he loves them and how reverently they requite his love with a love like the angels, so sweet and pure.

What wonder then that when he dies there falls upon these households a sense of irremediable loss and a never-forgotten sorrow! What wonder that his very name should long remain with them a household word, and a dear and abiding memory!

We are told that Michael Angelo, when he had heard of the death of a dear young friend, kindred in taste with his own, gave utterance to his grief in this wise:

> "And is Fra Bastian dead? Is all that light
> Gone out, that sunshine darkened, all that music
> And merriment that used to make our lives
> Less melancholy, swallowed up in silence
> Like Madrigals sung on the streets at night
> By passing travelers? It is strange indeed
> That he should die before me! 'Tis against
> The law of Nature that the young should die
> And the old live!"

The strangeness of death in youth or in mid-life which so powerfully impressed Michael Angelo has lost none of its mystery by the lapse of the centuries. Its shadow darkens the membership record of the Institute. Of the twenty-nine lost during the year just closing, eighteen died before reaching the twenty-fifth year of their membership, which entitles to the senior rank.

The occasion of this evening's gathering and of this our sorrow is the death of these twenty-nine colaborers. The salient points of their respective lives, their character and work have been given, so far as was obtainable, in the published proceedings of the last session, with two notable exceptions, for since those proceedings with their mortuary list were issued three of our most distinguished and honored members, Dr. William Tod Helmuth, Sr., Dr. Selden H. Talcott and Dr. Elias C. Price,

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have been taken from us. A brief sketch of their restive lives and brilliant careers cannot fail profoundly to interest you. These memoirs you will hear from the lips of others, from members who knew them more intimately than I, but did not love them more, and whose portraitures of their character and work will be more eloquent and impressive than would be possible to my own lips.

It remains to me publicly to express my profound sense of loss and sorrow, personally and as a society body, and to record our tenderest sympathy for and with all the near and dear of kin and heart in their respective and inexpresible bereavements. Our hearts in their tender condolence feel constrained to address them—

"Suffer on, thou sad and tired souls, suffer on,
Each throb of anguish bears the nearer rest,
That calm and quiet rest that speaks of growth.
Bear well your days of darkness, and, sure as the
Angel Justice lives, you shall not endure
All these days of suffering in vain.
Cheer up, thou sorrowing ones, night will not always last,
Cheer up, thou sorrowing ones, night will not always last,
The morn will surely come,
And thy tired, sad soul shall then find rest.
Seek and study better to know yourselves,
And so relate your every act to those around you
As to make the most of life."

And now, the great lesson for ourselves is this, that we so freshen our memories of these worthy dead, the memories of their virtues, their consecration and devotion to their exalted life-calling, their example of scholarly zeal and their kindly love towards the entire membership of the Institute as that they shall abide with us as an inspiring and hallowing benediction.

THEO. Y. KINNE, M. D.: IN MEMORIAM of our late brother, Dr. Wm. Tod Helmuth, Dr. H. F. Biggar will now speak.

Dr. Biggar made the following remarks:

Death is inevitable; it is not an annihilation, for "it cannot be that earth is man's only abiding place; it cannot be that our life is only a bubble, cast up by the ocean of eternity to float a moment on its waves and sink into nothingness, else why these high and glorious aspirations which leap like angels from the temple of our hearts, forever wandering unsatisfied? Why is it that the rainbow and clouds come over us with a beauty that is not of earth and then pass off to leave us to muse on their loveliness?

"Why is it that stars, which hold their festival around the midnight throne, are set above the grasp of our limited faculties, forever mocking us with their unapproachable glory?

"Why is it that the bright forms of human beauty are presented to our view and taken from us, leaving the thousand streams of our affections to flow back in Alpine torrents upon our hearts?

"We were born for a higher destiny than earth; there is a realm where the rainbows never fade; where the stars will be spread out before us like islands that slumber on the ocean, and where the beautiful beings that pass before us will stay forever in our presence."

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"Even for the dead I would not bind
My soul to grief—death cannot long divide,
For is it not as if the rose had climbed
My garden wall and blossomed on the other side?"

Death is not an annihilation; it is an évolution most joyous and blessed.

Do we not see it in the seed sown and the ripe grain gathered? And when life's work is fully done, it is timely, and when well-done then a blessing. It is a dreamless sleep, and should always be a welcome guest, for is there a more delicious sensation than comes from the falling of tired eyelids upon tired eyes?

"What would we give to our beloved?
The hero's heart to be unmoved?
The poet's star-tuned harp to sweep?
The patriot's voice to teach and rouse
The monarch's crown to light the brow?
He giveth his beloved sleep."

We are here to pay tribute to the worth and memory of a great man.

Men fill graves and are forgotten, but there are graves between the sky and the earth which cannot be filled.

"Of those immortal dead in minds—
Made better by their presence."

Dr Helmuth was great when living, and it is indeed a mark of greatness to be great when old. After many years have passed his memory will be held in esteem and admiration.

Great men are like great mountains. We do not fully appreciate their magnitude and their grandeur and their sublimity while viewing them from the foot-hills. Time and distance more clearly outline the peak which towers above its fellow, and after the lapse of years, in the bright galaxy of illustrious and representative men, Helmuth will stand out conspicuously prominent.

His life is a beautiful symphony that brain and industry and integrity are essential to success.

Those who were privileged to know Dr. Helmuth, either as an instructor or friend or counseler, will never forget the greatness and goodness of this gracious and charming man, who was always ready and willing to think the most good, and to speak the least ill of his brethren, and whose every act and desire was to weave heavenly roses into earthly life.

He was a born leader and possessed many rare accomplishments and talents, which were essential in developing and attaining his life work.

Education was the unfolding and the ennobling of his manly traits of character.

His life had such a charming influence and inspiration, a cultured gentleman of graceful dignity, his whole soul the very embodiment of all that is true, of all that is beautiful and of all that is good.

He was blest with a versatility of scholastic accomplishments.

His education and knowledge were broad, a profound thinker and one of the most genial of friends.

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He lived the doctrines which he taught and gained the respect even of his strongest opponents.

He gave character to, and adorned the profession he so dearly loved, and to him every homœopathic physician is largely indebted for the honored position which the surgery of our school has attained.

He was among the pioneers who paved the way and made the work easy for those who are now enjoying the blessings of their arduous labors in the surmounting of difficulties which beset this noble band of representative physicians.

His efforts to advance the cause of homœopathy were unselfish; it was not merely for personal aggrandizement; his motives were most laudable; forgetting himself, his one object was to advance the cause so dear to him. He was a brave, conscientious worker in his profession, and faithful and zealous in his chosen calling.

Dr. Helmuth was a genius, for he cultivated a capacity for taking infinite pains; his work was carefully planned and systematically executed. He had not forgotten that it was close attention to detail that gained Waterloo.

He gave his own personality a charm that caused him to be loved of men as few men are loved.

Our associations with him were delightfully profitable; we felt enriched by his words of sound, practical thought, which strengthened the bonds that bound us together in common fraternity.

We shall miss him in the councils and deliberations of our medical gatherings, where he was so distinguished. We shall miss the matured and classic thoughts, whether as a poet, or physician, or surgeon, we have all read with pleasure and with profit.

His death is not restricted to the environments of the great metropolis, nor to the national boundaries of this vast Republic. It is an irreparable loss to the English-speaking communities, and wherever homœopathy is known.

It needs no tongue to utter his praise, nor swift pen to write his eulogy; it needs no skilled artificer in marble or bronze to perpetuate the memory of this great and illustrious scholar, and famous and distinguished surgeon.

At the death of the maker of a thousand bells, at a certain hour, these bells were tolled, not only to commemorate his death, but as a sad responsive requiem in sweet accord with most harmonious and musical rhythms of perfect toned bells.

How many thousand living tongues are singing the praise of this good doctor, who, by his superior skill, brought such joy to many hearts and homes.

To live in the hearts he leaves behind is not to die.

Greater love hath no man than this, that a man lay down his life for his friends.

Come ye blessed of my Father—I was sick and ye visited me.

His life is a beautiful exhortation "to know the true, to love the good, to do the right," admonishing us not to pray for easy lives, but to become stronger men—not to pray for tasks equal to our powers, but for powers equal to our tasks. May we imitate the life of this great man, to "do noble things, not dream them all day long, and thus make life and death, the great hereafter, one grand and loving song."

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The following poem by Dr. A. C. Cowperthwaite concluded the exercises:

The day is done, the twilight deepens into night,
And shapes and shadows disappear
As darkness most profound
In awful stillness settles over all,

Thus ends each earthly life, so far as human gaze can penetrate;
The throbbing heart is stilled,
The pulse has ceased to beat,
The eyes once filled with light and love and joy no recognition give,
The mind once active now has passed
Into a slumber so profound and deep
That naught on earth can waken into life.

And this is death! And through its gloomy portals each must pass,
Nor can he find another way—
'Tis this and only this awaits us all
The end of earthly life.

It comes to each and every one alike—
The same grim monster, dreaded, undesired, unbidden as a guest,
And yet it comes and 'gainst its coming naught prevails.
Nor can we lift the veil and see with human eyes
Beyond the gloom that shrouds the present and the future in a pall—
The blackness of eternal and unending night.

Oh! human eyes, how weak your power of sight,
Oh! human soul, how strong your hold on Infinite.
Embedded deep in every heart,
Secure from sceptic's wiles and tempter's dart,
There rests a certainty, a fact—
We know not how, or when, or where,
But death is not the end.

As twilight follows day and settles into night
So night precedes the dawn and dawn the light,
The glorious light of never ending day.
The morning breaks, the night has disappeared,
The sun's effulgent rays shine through the gloom
And dissipate the awful darkness of the tomb.

The body once so comely to our sight,
Holding within its frame the love and light
Of life divine;
The flashing eye revealing thoughts and passions deep,
The voice we loved to hear and lingered o'er its sound,
The touch that brought to each responsive chords—
That body worn with disease and racked with pain
Has passed away.
Its once familiar form will no more greet our eyes,
Its touch has vanished and its voice
Will ne'er again awake our lives to pleasant melodies.
But that which made this body all we held most dear
Still lives. We know not how or where,
Wrapt in impenetrable mystery, but yet it lives.
The soul that gleamed from out those loving eyes,
That gave to touch and voice its power and thrill—
The life that lived still lives,
And in its living gives to each who here remain
An inspiration deep and true.

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E'en now, mayhap, from some celestial shore
That soul takes flight and hovers o'er
As we in solemn conclave speak its worth,
And in our sorrow at its loss frame on our lips
And echo in our hearts a sad farewell.
Let sadness then be banished from our theme
And joy and gladness fill our hearts supreme;
Those who have lived and filled a purpose true,
Still live and with us here again renew
A pledge of love, and which through coming years
Shall give us strength to overcome all fears
As we in turn approach that dreaded hour,
When failing breath and dimming eye, and waning power,
Warns us the last dread messenger's approach,
Against whose coming fame and title never may encroach.

Then may we meet the darkness of the night
With fortitude and trust, the coming light
Already dawning in our hearts give strength and joy,
Which earthly ties and morbid fears cannot alloy.

And so, to those against whose names the asterisk of death to-night is set,
To one and all we say "Farewell," "Good Night," and yet
As to-morrow's sun in rising marks the flight of time,
So each of us 'ere long will say "Good morning" in a happier clime.

FIFTH DAY

SATURDAY, JUNE TWENTY-FIRST
1902

The fifth and last day's meeting of the Institute was called to order at 9:30 a. m. by President Wood.

Dr. Millie J. Chapman, Chairman of the Board of Censors, reported that the list of fourteen applicants whose names were presented yesterday has been posted the due length of time, and the Board of Censors ask their election.

Dr. A. C. Cowperthwaite moved that the report be concurred in and the applicants elected to membership.

Motion seconded and carried.

Dr. Millie J. Chapman also presented eight names of applicants for membership.

Dr. Millie J. Chapman: Mr. President, I ask on behalf of the Board of Censors that the by-laws be suspended and these persons elected this morning.

Motion seconded, and duly carried.

Dr. T. Franklin Smith then read the following report from the Committee on Organization, Registration and Statistics:

To the Members of the American Institute of Homoeopathy: Your Committee on Organization, Registration and Statistics would respectfully make the following report:

There are in the United States nine National Homœopathic Societies, of which reports have been received from five; three Sectional or Inter-State Societies, two of which have reported; thirty-four State Societies,

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from twenty-six of which reports have been received; ninety-five Local Societies, sixty-eight of which have reported; forty-three Homœopathic Medical Clubs, of which reports have been received from thirty-two; there are eight Alumni Associations, seven of which have sent in reports; there are in addition to all these three miscellaneous Homœopathic Associations, all of which have reported.

There are in the United States eighty-one General Hospitals, in which homœopathic practice is employed either entirely or in part; from these reports have been received from only forty-six; thirty-three Special or Private Hospitals have reported out of a total of sixty-two; there are fifty-nine Homœopathic Sanatariums, and reports have been received from only twenty-seven of them; out of sixty-six Institutions where homœopathic practice is employed, only twenty-one have reported. There are fifty-five Homœopathic Dispensaries, and reports have been received from thirty-one of them. The forty-six General Hospitals reporting, have a capacity of 4,254 beds, and 38,689 patients have been treated during the past year; the thirty-three special and private hospitals reporting have a capacity of 6,000 beds, and 11,885 patients have been treated during the past year; the twenty-seven Sanatariums reporting have a capacity of 1,016 beds, and have treated during the past year 6,828 patients; the twenty-one Intitutions under homœopathic treatment reporting have a capacity of 2,118 beds, and have treated during the past year 2,255 patients; the entire number of 127 Hospitals, Sanatariums and Institutions reporting show a capacity of 13,388 beds, and 52,657 patients have been treated.

There are in the United States fifty-five Homœopathic Dispensaries, and reports have been received from thirty-one of them; these Dispensaries report as having treated during the last year 176,757 patients, have made 573,938 prescriptions, and 25,262 outside visits. A very large majority of these dispensaries do not make any outside visits, but simply prescribe for such patients as come to their rooms.

There are in the United States twenty Homœopathic Colleges, from which we have received reports from all, with the exception of the New York College and Hospital, the New York College and Hospital for Women, and Hahnemann Medical College of Philadelphia. We hope to receive reports from these before our report is printed in the Transactions. The reports from the seventeen colleges that have sent us reports show that during the last year there have been nine hundred and seventy-three students in attendance, with one hundred and ninety-five graduates. There are in all 7,995 Alumni; 321 Professors, 209 teachers. The value of the College property is placed at $1,076,400. There are endowments to the amount of $199,250. The total amount of debt is $259,-500. The total income is $104,800.

There are thirty homœopathic journals printed in the United States.

All of which is respectfully submitted.

THOS. FRANKLIN SMITH, *Chairman.*

DR. T. FRANKLIN SMITH: Your Committee would ask that they have the privilege of inserting in the Transactions such reports as may come in subsequent to this meeting.

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THE PRESIDENT: If there is no objection the report will be received and take the usual course.

DR. C. B. KINYON, of the Committee on Election, then presented the following report:

The number of ballots cast and counted was 285; of these Dr. Joseph P. Cobb received 151, and Dr. W. H. Hanchett 134; majority for Dr. Jos. P. Cobb, 17.

THE PRESIDENT: The chair declares Dr. Joseph P. Cobb your President-elect. Next in order will be reports of Committees which have failed to report up to the present time.

DR. A. C. COWPERTHWAITE, on behalf of the Committee on the President's Address, then presented the following report:

REPORT OF THE COMMITTEE ON PRESIDENT'S ADDRESS.

The Committee on President's address desires to express its hearty and very general endorsement of Professor Wood's views.

We especially commend his interpretation of the present status of homœopathy—its broadening influence upon the progressive medical thought of the last century, and his belief that its influence is still operative, and for years to come will remain operative in maintaining homœopathy as a specialty in therapeutics.

We recognize the dogmatic spirit of Hahnemann, to which reference has been made, to be the outgrowth and natural sequence of the non-receptivity and bigotry of the time in which he lived. While we deplore the necessity for such a professional attitude, we are of the opinion that it was necessary for the development, the growth and the very existence of homœopathy. The mysticism characterizing some of Hahnemann's theories serves to show the human element, but it in no way detracts from the lofty scientific basis of his work.

We recognize the current tendency toward medical affiliation throughout the land, but inasmuch as a recognition of the law of similars is still withheld, we commend the attitude of the President in urging continued separate organization.

So long as the therapeutics of the old school is destitute of a guiding law, the strenuous promulgation of the law of *homœopathy* is a necessity, and our present organization must be maintained.

We would in no way discourage or obstruct the advent and widespread adoption of sentiments of fraternity and toleration among medical men, but until there shall be evidences of mutuality and reciprocity among men of varied faiths in medicine—to give as well as to receive—there can be no furling of colors or abandonment of distinctive organization. This attitude is, for the present, at least, imperative, in order that the interests of our school may be protected and that the truths of homœopathy may be disseminated.

We further recommend that the address be published in pamphlet form for distribution.

JAMES W. WARD, M. D., *Chairman;*
O. S. RUNNELS, M. D.
H. P. BELLOWS, M. D.

DR. BUSHROD W. JAMES: I move that the report be received and the recommendations adopted.

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Motion seconded, put by the Vice-President, and carried.

DR. J. B. G. CUSTIS: Mr. President, I like that report very much, and if the President's address is published in pamphlet form for general distribution, as I suppose it will be, I would like to have the report of the Committee appended to the address. It is explanatory, and should be in the pamphlet containing the President's address. I move that as an amendment.

The amendment was accepted by the committee.

DR. A. C. COWPERTHWAITE: As far as the Committee is concerned, that would be very acceptable, and I think it would be very wise, not only for the instruction of the members, but as showing the feeling of the Institute on the subject.

Motion put by the Vice-President, and carried.

DR. J. P. SUTHERLAND presented the following report of the Inter-collegiate Committee:

MR. PRESIDENT: Your Inter-Collegiate Committee desires to bring to your notice the fact that, notwithstanding the rapid extension of homœopathic practice in the United States there are very many fields unoccupied and others inadequately occupied by homœopathic practitioners. There are not in attendance upon our colleges a sufficient number of students to meet the demands that are being made upon us for physicians. We therefore recommend that the following circular be adopted, and that copies be mailed to all our Homœopathic journals and to one thousand newspapers of the United States, with the request for editorial notice of the facts contained in the circular.

PUBLIC DEMAND FOR HOMEOPATHIC PHYSICIANS.

The demand for homœopathic physicians throughout the United States far exceeds the supply. Thousands of small cities, towns and villages are unable to secure the advantages afforded by the homœopathic system of medical practice. Demands for graduates of this school of medicine are constantly reaching our twenty colleges. The demands for physicians come from every state in the Union. Especially is this true of the Southern and Southwestern states, into which thousands of people in quest of pleasure, health and business are going every year. The American Institute of Homœopathy, mindful of her obligation to the public, not only calls attention to this public need but also to the fact that there are twenty medical colleges in the United States, thoroughly equipped effectively to teach all branches of medicine and the science and practice of homœopathy. These colleges earnestly solicit, and will welcome, young men and women of good moral, physical and mental endowment, possessing a high-school education or its equivalent, with an elementary knowledge of Latin. Those who come from districts having but few homœopathic physicians will be especially welcome.

DR. J. B. G. CUSTIS: I move that the report be received and the recommendations adopted.

Motion seconded and carried.

DR. SUTHERLAND: The committee also asks the adoption of the following resolution:

Resolved, That it is the sense of the committee that the National Medical University, of Chicago, be denied recognition in the Inter-Collegiate Committee of the American Institute of Homœopathy.

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On motion the resolution was adopted.

A. W. BAILY, M. D., for the Committee, presented the following report:

REPORT OF THE LEGISLATIVE CONFERENCE COMMITTEE.

Your Legislative Conference Committee begs leave to report that as the nature of the work entrusted to its care requires much time in observation of the animus and attitude of the general medical profession in relation to the important question with which we have to deal, thoughtful consideration of the observations we make, and great caution in action, no definite results can be reported at the present session of your body. We feel sufficiently encouraged, however, to report progress in our work, and recommend that the Committee be authorized to continue its work, from which more definite results may be expected in the future.

Respectfully submitted,

ELBRIDGE G. PRICE, *Chairman*,
A. W. BAILY,
W. H. HANCHETT.

DR. W. H. HANCHETT, of the Inter-State Committee, presented the following report:

The Inter-State Committee have had three regular sessions, at which the questions pertaining to the inter-state work have been thoroughly discussed and recommendations made. First, we recommend that all of the States where societies are not formed take up the work during the coming year. One or two of the States in the Union have discussed the matter, and have called meetings, but decided to form no societies on account of the small number of homœopathic physicians residing within the State. One of these States is Georgia. Our friend, Dr. H. M. Paine, on this Committee, called a meeting at Atlanta, and it was decided that there were so few physicians in the state of Georgia that it would be perhaps inexpedient to form a society. This committee urges all members of the Institute to return to their States, and even though the number be small, at once to form a society. This, we think, will mean much to our school. Another recommendation which they have made is that in questions of state medical boards that they form a riciprocity between the States in their own nieghborhood. This has been done in many parts of the Union. Another recommendation of the Committee is that the time has come when there is a great lack of homœopathic practitioners, and that this fact be made public as far as possible, and the locations given to the various colleges throughout the country, that these localities may be supplied.

It was moved that the report of the Committee be received and the recommendations adopted. Motion carried.

THE PRESIDENT: Under the head of unfinished business, I will recognize DR. GEO. ROYAL.

DR. GEO. ROYAL: Mr. President and Members: We all know that we have had one of the most successful sessions in years, and with the adoption of our new Constitution and By-laws, and the prevailing universal good feeling, we have been looking forward to still further improvement. One of these, I believe, will be a Nominating Committee,

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and after conference with many of those who have the best interests of the Institute at heart it is thought best to give notice that next year we will ask that Article IX., Section 8, of the By-laws be amended, making the ex-presidents of the Institute a nominating committee.

THE PRESIDENT: The report will be received and take the usual course.

DR. FRANK L. NEWTON: I wish to make a similar recommendation. In view of the experience that we have had in the last few years in our methods of election, I desire to propose an amendment to the By-laws, Article IX., Section 8, striking out the lines beginning with the word "Nomination" in the sixth line of this printed matter as we have it before us, and ending with the words, "*ex-officio,*" in the twenty-second line, inclusive, substituting therefor the following:

"There shall be appointed by the President at each annual session a Nominating Committee, which shall comprise one member from each state of these United States represented in the Institute. The President shall appoint a Chairman *pro tempore*, he to appoint a Secretary *pro tempore*. It shall be the duty of said Committee to organize by the election of a permanent Chairman and Secretary. They shall nominate by ballot two candidates for each elective office and prepare an official ballot."

I offer this because of certain observations that I have made in the last five years in regard to the election of officers in this Institute.

THE PRESIDENT: The notice will be duly received.

DR. GEO. B. PECK: Mr. President, I respectfully give notice that next year the following amendments to the constitution will be presented:

THE CONSTITUTION: Amend Article III. by inserting the words "An Assistant Secretary" at the beginning of the fourth line.

THE BY-LAWS: Amend Section 3, Article II., by adding the words "The Assistant Secretary shall be paid a salary of $200."

Amend Section 4, Article III., by substituting in the first and second lines the words:

"The Assistant Secretary shall perform such duties as are required of him by the Secretary. It shall be his special duty," for the words "It shall be the special duty of the Secretary."

THE SECRETARY: Mr. President, the Secretary has received the following resignations:

Dr. W. T. Schoonhover, Greenfield, Pa.; Dr. Sue E. Hertz, Detroit, Mich.; Dr. N. G. Stanton, Newport, R. I.; Dr. A. B. Avery, Pontiac, Mich.; Dr. Frank F. Marsh, Warren, Mass.; Dr. Van R. Tyndall, Philadelphia, Pa.; Dr. Thomas E. Roberts, Oak Park, Ill.; Dr. A. E. Neumeister, Kansas City, Mo.

I move that the resignations be accepted.

Motion seconded and carried.

THE PRESIDENT: The Chair will now announce the remaining Committees and new Chairmen for the ensuing year. Preliminary to this announcement I desire to say that I have tried to cover the various sections of the country as well as I could, having always in mind the good available material. I have also tried to inject a good deal of new material into these various committees.

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COMMITTEES.

COMMITTEE ON ORGANIZATION, REGISTRATION AND STATISTICS: T. Franklin Smith, M. D., *Chairman;* John W. Coolidge, M. D.; John C. Budlong, M. D.; Chas. E. Kahlke, M. D.; John G. Aiken, M. D.

COMMITTEE ON TRANSPORTATION: C. E. Sawyer, M. D., *Chairman;* J. Herbert Moore, M. D.; P. J. Montgomery, M. D.

PRESS COMMITTEE: DeWitt G. Wilcox, M. D., *Chairman;* Clarence Bartlett, M. D.; S. H. Aurand, M. D.

COMMITTEE ON RESOLUTIONS AND BUSINESS: B. F. Bailey, M. D., *Chairman;* S. H. Knight, M. D.; Geo. W. Roberts, M. D.

COMMITTEE ON MEMORIAL SERVICES: Edward Beecher Hooker, M. D., *Chairman;* O. S. Runnels, M. D.; C. B. Kinyon, M. D.

COMMITTEE ON PROPOSED CHANGE IN THE PUBLICATION OF THE TRANSACTIONS: Chas. E. Walton, M. D., *Chairman;* Horace Packard, M. D.; D. M. Gibson, M. D.

INTERNATIONAL BUREAU OF HOMŒOPATHY: Geo. B. Peck, M. D., *Chairman;* J. B. Gregg Custis, M. D.; D. A. Strickler, M. D.; Conrad Wesselhoeft, M. D.; Florence N. Ward, M. D.

COMMITTEE ON DRUG-PROVING: Howard P. Bellows, M. D. (1 year); J. Perry Seward, M. D. (2 years); Chas. Mohr, M. D. (3 years); Eugene B. Nash, M. D. (4 years); Matilda J. Lyons, M. D. (5 years).

COMMITTEE ON MEDICAL EXAMINING BOARDS AND MEDICAL LEGISLATION: H. H. Baxter, M. D., *Chairman;* Jos. H. Cowell, M. D.; W. E. Green, M. D.; J. M. Lee, M. D.; Chester G. Higbee, M. D.: Eldridge C. Price, M. D.

CHAIRMEN OF BUREAUS.

MATERIA MEDICA AND GENERAL THERAPEUTICS: George Royal, M. D.

CLINICAL MEDICINE AND PATHOLOGY: Jno. W. Dowling, M. D.

HOMŒOPATHY: T. Y. Kinne, M. D.

PEDOLOGY: Annie Whitney Spencer, M. D.

SANITARY SCIENCE AND PUBLIC HEALTH: Jno. P. Sutherland, M. D.

DR. J. B. G. CUSTIS: Mr. President, we feel that this has been one of the greatest sessions we have ever had, and we want to express our appreciation of the hospitality of the Local Committee and of the citizens of Cleveland. I therefore move that we give a vote of thanks to the Local Committee and the citizens of Cleveland and the press for their most hospitable entertainment and courteous treatment.

The motion was duly seconded, and carried unanimously by a rising vote.

DR. J. B. G. CUSTIS: I also move that we extend a vote of thanks to our worthy President for the highly satisfactory manner in which he has presided over the meeting, and the fairness with which he has decided all disputed points.

Motion seconded.

DR. E. B. HOOKER, Vice-President, put the motion and it was unanimously carried.

DR. JAS. C. WOOD, President: Mr. President, Ladies and Gentlemen: In behalf of the Local Committee I wish to say to you that the pleasure has been ours, and that it has been good for us to have you with us. We believe not only that it has been a good thing for the

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Institute to meet in our city, but we believe also that it will be a good thing for Homœopathy in this locality, as well as throughout the country. At the same time I want to say that the success of his meeting has been due in large measure to the hearty co-operation which the Local Committee here has given me. The Local Committee have worked harmoniously, have worked unanimously. There has not been a single solitary word of discord, and I feel that it is proper that I, as President, occupying the somewhat unique position of presiding over your deliberations in my own city, express to them my sincere and profound gratitude for their hard and earnest work. I certainly thank you, ladies and gentlemen, from the bottom of my heart, for the manner in which you have aided me and assisted me in making this one of the most successful meetings in the history of the Institute. We have admited about 160 members. I wish it might have been 500, but that is doing pretty well. We have brought into our fold a large number of members from this locality, men and women who never would have gone into the Institute if we had not met in Ohio. I believe that the prospects of the Institute were never brighter than they are at the present time. I certainly feel proud in turning it over into the new hands, and I thank you, not only for myself, but on behalf of the Local Committee and the local profession, for all that you have done to make this week quite as pleasant for us as it has been for you. Is there any other business?

DR. A. B. NORTON: Mr. President, before adjournment I would like to state that the President-elect is in the room, and I would like to call upon him.

THE PRESIDENT: Dr. Cobb.

DR. JOSEPH P. COBB, the President-elect, stepped upon the platform, and was greeted with applause. He spoke as follows:

Mr. President and Members: I think you do not expect any extended remarks from me this morning, but with this opportunity given me I should feel recreant to myself if I did not express my appreciation of the high honor and the great trust which you have bestowed upon me. I want to thank you for this exhibition of your kindly judgment, and to say that I accept the trust and shall labor with my whole heart for the interests of Homœopathy, for the interests of the Institute, and for the interests of all. I thank you.

THE PRESIDENT: Is there any further business?

DR. GEO. B. PECK: As Acting Registrar for this session of the Institute I would respectfully report that upwards of 500 members have been registered, over 50 of whom were seniors, and that at least 450 guests were registered, making a total of at least 950.

THE PRESIDENT: Making nearly a thousand persons in attendance. Is there any other business? If not, I declare the session for the year 1902 of the American Institute of Homœopathy to be adjourned without day.

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REPORTS

OF THE

SCIENTIFIC SECTIONS

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SECTION IN
CLINICAL MEDICINE AND PATHOLOGY

WM. H. VAN DEN BURG, M. D.
CHAIRMAN

GENERAL SUBJECT — GASTRIC ULCER

ETIOLOGY AND PATHOLOGY OF GASTRIC ULCER..WM. A. GEOHEGAN, M. D.

SYMPTOMATOLOGY OF GASTRIC ULCER.....A. B. SCHNEIDER, M. D.
DISCUSSION: *Arthur E. Thomas, M. D.*

DIAGNOSIS OF GASTRIC ULCER.....J. HERBERT MOORE, M. D.
DISCUSSION: *William Wallace Gilbert, M. D.*

TREATMENT OF GASTRIC ULCER.....FREDERICK J. NOTT, M. D.
DISCUSSION: *W. B. Hinsdale, M. D.; S. H. Aurand, M. D.; L. C. Grosvenor, M. D.; J. B. G. Custis, M. D.; Geo. S. Coon, M. D.; J. Herbert Moore, M. D.; Wm. H. Watters, M. D.; C. E. House, M. D.*

SURGICAL TREATMENT OF GASTRIC ULCER.....W. H. BISHOP, M. D.

TREATMENT OF GASTROPTOSIS.....CONRAD WESSELHOEFT, M. D.

OBSERVATIONS ON HYPERCHLORHYDRIA.....O. S. HAINES, M. D.

TREATMENT OF HYPERCHLORHYDRIA.....H. V. HALBERT, M. D.
DISCUSSION: *T. E. Costain, M. D.; C. B. Gilbert, M. D.*

SPECIFIC TREATMENTS.....WM. C. GOODNO, M. D.
DISCUSSION: *J. B. G. Custis, M. D.; H. V. Halbert, M. D.; S. H. Aurand, M. D.; J. Herbert Moore, M. D.; C. B. Gilbert, M. D.*

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ETIOLOGY AND PATHOLOGY OF GASTRIC ULCER

WM. A. GEOHEGAN, M. D.
CINCINNATI

Gastric ulcer shows great diversity both in its etiological factors and its pathological manifestations. It may exist for a long time without producing any marked symptoms. Indeed, from the frequency with which healed ulcers are found at autopsies it is evident that the process may run its entire course unsuspected. In the majority of cases the disease has probably been latent for a considerable time before the first characteristic symptoms appear. This renders it difficult to trace etiological relationships.

Pathologically, gastric ulcer is characterized by loss of tissue of one or more coats of the stomach. Clinically, in typical cases, it is manifested by localized pains, vomiting of food and blood, and by hyperacidity of the gastric contents.

Two forms are generally recognized. The *acute* is a purely necrotic process, extending rapidly in depth within clearly defined limits, giving to the ulcer an appearance "as if cut out with a punch." The edges are not swollen or infiltrated, and there is an entire absence of inflammatory changes. It shows little tendency to heal, but when it does so there is no marked cicatricial puckering. The *chronic* form gives evidence of protracted inflammatory action. The edges lack the clearly-cut appearance of the acute type, but are thickened and shelving, and give to the lesion a funnel shape. Its floor is dense and fibrous. The ulcer shows more tendency to heal than the acute variety. Owing to its greater area and the extensive deposit of newly-formed connective tissue, cicatrization results in marked contraction and deformity of the organ.

Both are alike in their tendency to penetrate blood-vessels and cause hemorrhage. Either may perforate the walls of the stomach, and, directly by extension, or indirectly by escape of the gastric contents, cause general peritonitis. If adhesions form the ulcerative process may invade adjacent organs and cause hemorrhages from them, or abscesses in their substance.

Clinically it is not always possible to differentiate the acute and chronic forms. When the characteristic symptoms of the disease have existed for less than one month the acute type of ulcer is usually revealed at the autopsy. If they are of longer duration the chronic form is generally found. There seems to be no criterion by which we can determine

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if the chronic form is essentially so from the beginning, or is merely a later stage of the acute type.

Ulcer of the stomach, recent or cicatrized, is found in from three (3) to ten (10) per cent of all autopsies. It is rare in infancy and early childhood, attains its maximum from twenty (20) to thirty (30) years in females, and from thirty (30) to forty (40) years in males, and becomes comparatively rare after middle age. All concede that it is more frequent in women than in men, but the proportion given by different authorities varies from two (2) to twenty (20).

Occupation seems to have little influence in its causation. Cooks are said to be prone to it from the frequent ingestion of very hot foods; metal-turners from swallowing small particles of metal; and tailors, shoemakers, weavers, and porcelain-painters from mechanical pressure upon the epigastrium due to the continued cramped position incident to their vocation. It is somewhat more frequent in the poorer and laboring classes. While there is general agreement regarding the predisposing causes of gastric ulcer as stated, we find marked differences in the statistics adduced in their support.

In reference to the exciting causes, so many theories are advanced in current literature that it is evident none of them is perfectly satisfactory, or at all generally applicable.

Many of the more plausible theories center about the fact that the stomach of an animal killed at the height of the digestive process may undergo partial self-digestion if the body is kept warm. It has never been fully determined what prevents the auto-digestion of the stomach in health. That it is not alone due to the alkalinity of the blood is evident, for in all organisms, even the lowest form of life, there seems to be exemption from self-digestion. The simplest unicellular organisms, the plants containing digestive ferments and the insectivorous plants would otherwise destroy themselves. The pancreatic fluid and the *succus entericus* act upon proteids in an alkaline medium, but do not attack the intestinal walls. The vegetable digestive ferments, which are said to act with equal vigor in acid, alkaline or neutral media, do not cause ulcer of the stomach. The degree of alkalinity of the blood is too slight to neutralize even the normal amount of hydrochloric acid. We are compelled to admit that the immunity of the stomach from auto-digestion is due to chemical or physical qualities, or, in more general terms, to fundamental vital forces of which we have no definite knowledge. But when an ulcerative or necrotic process is once established, the digestive action of the gastric fluid has an influence in its extension and perpetuation that is readily understood.

Traumatic lesions of the gastric mucous membrane of healthy animals heal rapidly and this has led to the conclusion that for the

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production of ulcer of the stomach there must be an abnormal condition of the blood in addition to the injury of the mucosa. In animals artificially rendered anemic; or in which the trophic nerves of the stomach are divided; or when substances are given which disintegrate the blood lesions no longer heal rapidly, but leave ulcers.

A large proportion of all cases of ulcer of the stomach coexists with, or follow, a high degree of anemia, usually of the chlorotic type. The altered alkalinity of the blood is not necessarily the one factor leading to the necrotic process. Ewald suggests that it is more probably due to insufficient nourishment of the cells resulting from the deterioration of the blood.

Virchow attributed the majority of gastric ulcers to thrombi and embolism resulting from changes in the blood, or in the vessels due to degeneration of their walls. To this theory it has been objected that it is impossible to demonstrate occlusion of the vessels in many cases, and often when it is present it is the result of the inflammatory process. Gastric ulcer is rare in the aged, in whom degeneration of the arterial walls is most frequent.

Brunton and others attribute gastric ulcer to some initial superficial erosion or ulceration, which is afterward deepened and rounded in its contour by peptic action. Akin to this is Peter's view that gastritis, by its influence upon the circulation, permits the auto-digestion. These theories fail to explain the absence of peptic ulcer following the frequent erosions and hemorrhagic ulcers in alcoholic gastritis, and why the round ulcer is generally single.

Hemorrhages into the walls of the stomach do sometimes undergo digestion and leave an ulcer. Balzer claims that abscesses form between the coats of the stomach and rupture into its cavity, the lesion being increased in extent by digestive action.

Tuberculosis is conceded to be a very rare cause, and it is said that less than fifty cases due to it are recorded. Ulcer of the stomach, however, may favor the development of tuberculosis.

Syphilis is a more important factor, one writer attributing twenty (20) per cent of all cases to it. This figure is undoubtedly too high. It causes occlusion of the vessels by endarteritis and consequent ulceration. The ulcers forming upon gummata are not typical gastric ulcers.

Traumatism may cause symptoms similar to ulcer of the stomach, but a solution of continuity is not always found post-mortem. Injuries of the stomach tend to heal rapidly in persons otherwise in good health. Ulcers of the stomach may co-exist with those of the duodenum due to burns.

Von Sohlen finds gastric ulcer rare in those living upon a vegetable diet rich in the potassium salts, which substances, he believes, act in

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some measure as a preventive. He cites the fact that grass-eating domestic animals rarely have this disease. Sydney Martin's views are evidently not in accord with this theory, for in endeavoring to account for the larger proportion of cases in the poorer classes he attributes it to an excess of vegetable food in their dietary.

Yzeren reports experiments on rabbits in confirmation of Talma's theory, that gastric spasm is the cause of peptic ulcer. Division of the vagi below the diaphragm caused spasm of the muscular coat, ischemia of the mucous membrane, and necrosis with subsquent ulceration. The ulcers were single and in the pyloric region.

Klebs has a theory attributing gastric ulcer to local ischemia, caused by spastic arterial contractions.

Stokes reports a case in which Klebs-Lœffler bacilli swallowed during an attack of diphtheria caused necrosis and ulceration of the gastric mucous membrane on the greater curvature near the pylorus. The necrotic material contained the bacilli in abundance. Walsh reports cases in which pure cultures of pneumococci were present in the ulcer, although pneumonia was absent.

Longridge cites experiments of Enriquez and Halwin, in which the injection of diphtheric toxin beneath the skin of guinea pigs caused an ulcer of the stomach; and Flexner's experiment on toxalbumic intoxication produced similar results. The theory advanced is that the poison being excreted by the gastric mucous membrane caused death of the cells with which it came in contact, necrosis and ulceration ensuing.

Hyperacidity of the gastric contents is present in over ninety per cent of all cases of peptic ulcer, but in the remainder there may be a marked deficiency. Many authorities believe this condition to be an important etiological factor, while others consider it merely a symptom, and by no means pathognomonic. It seems probable that erosions, hemorrhages, infarcts and deterioriation of the blood more frequently led to an ulceration, when a very acid condition of the stomach exists. While the irritation of the ulcer may excite hypersecretion, it has been proven that many injuries of the stomach do not lead to excess of hydrochloric acid, and that ulcers may exist without increased secretion. It is interesting to note that Einhorn and others have found hyperacidity of the gastric contents as a rule in chlorosis and anemia, even when no ulcer of the stomach existed.

Only a few of the many theories of the etiology of gastric ulcer have been mentioned, but they suffice to show the unsatisfactory state of our knowledge regarding it, and the probability that a great variety of causes are concerned in its production.

The general facts regarding the pathological anatomy of this affection are so clearly and uniformly stated in our text-books as to merit

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little attention at this time. The ulcers are single in the majority of cases, multiple in perhaps twenty-two per cent. Frequent mention has been made of one case in which thirty-four (34) existed. Ulcers occur most frequently about the lesser curvature and posterior wall of the stomach, especially in the region of the pylorus. The anterior wall is rarely affected, but more frequently in the acute form than the chronic.

Hemorrhage occurs in fully eighty (80) per cent of all cases. Bleeding is by no means a criterion by which to judge of the severity of a case. It is nearly always present in non-fatal cases, in fact a diagnosis can scarcely be made without it. It is sometimes absent in fatal cases. Hematemesis may be present without ulceration, Pye Smith comparing it to the nose-bleeding of young boys without apparent lesion. Dieulafoy refers to severe hemorrhages from so-called erosions occurring in the form of bleeding points. Einhorn doubts the origin of the free bleeding from such insignificant erosions, and believes they are due to co-existing infectious diseases. Hematemesis is more fatal in males than females.

Perforation occurs in about three (3) per cent of all cases, and is invariably fatal unless the injury is repaired by operative procedure.

By the healing of extensive ulcers of the chronic type the organ may be distorted even to the extent of producing hour-glass contraction or stenosis of the pylorus.

Marked thickening of the base of a chronic ulcer has often led to an erroneous diagnosis of tumor or cancer.

Evidence is accumulating in support of the claim that carcinoma may become engrafted upon ulcer of the stomach.

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THE SYMPTOMATOLOGY OF GASTRIC ULCER

A. B. SCHNEIDER, M. D.
CLEVELAND

In considering the symptomatology of gastric ulcer we are confronted with the fact that in many cases of this affection the symptoms are suggestive of nothing more than a chronic gastritis. In fact, gastric ulcer is not infrequently found at autopsy in cases in which its existence had not been suspected, and in which death has been due to other causes. Occasionally, too, death speedily supervenes upon a profuse gastric hemorrhage, or occurs as the result of a perforation of the stomach, unheralded by the symptoms which are so characteristic of typical ulcer of the stomach. Commonly, however, the three cardinal symptoms of ulcer, viz., pain with tenderness, vomiting, and hemorrhage, present themselves sooner or later. These characteristic indications are, however, not invariably associated, nor are their distinctive features always prominently developed.

Pain is perhaps the most distinctive symptom, and is rarely absent. Beginning as a vague sensation of pressure or discomfort, with occasional transient drawing pains, it soon becomes dull and heavy and continuous, and frequently changes to a gnawing sickening sensation quite distinct from nausea. It becomes more severe after eating and continues so as long as food remains in the stomach, being relieved by vomiting and the completion of digestion, and subsiding markedly when the stomach is at rest. Pressure intensifies the soreness and is especially painful over a sharply circumscribed area which indicates the site of the ulcer. This tender spot is usually located in the center of the epigastrium, but is sometimes found to the right or left of the median line or behind the ensiform cartilage. Coming on a few weeks later and associated with this epigastric pain is a severe gnawing, burning pain, usually referred to the left of the lower thoracic or upper lumbar vertebræ. This sometimes extends to the scapulæ or to the coccyx, but is generally also sharply localized and also subject to aggravation by pressure. The dorsal pain is sometimes the first to appear, and is said to be more severe when the ulcer is in the posterior wall of the stomach.

Besides this continuous distress there are severe paroxysms of boring, lancinating, gastralgic pains, which come on suddenly, and which are usually induced by taking coarse or irritating food. Thermal irritation is detailed as a cause when even small quantities of hot or cold food bring on the paroxysms. In cases in which the paroxysms occur

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when the stomach is empty the pain is doubtless due to the direct action of the hyperacid gastric juice upon the exposed nerve-filaments in the bottom of the ulcer. Anger, fatigue, and the increased nervous and vascular tension preceding menstruation frequently act as exciting causes. Pressure and the taking of food sometimes relieve this gastralgic pain.

Vomiting is present in the majority of cases, but may be replaced by acid regurgitation or nausea. It usually takes place several hours after eating, although it may occur immediately after taking food. During the paroxysms of gastralgic pain the vomiting usually occurs at the height of the attack and affords marked temporary relief. It is more frequent when the ulcer is near the pylorus, the stenosis resulting from thickening of the base of the ulcer or from reflex contraction of the pyloric sphincter doubtless being the cause. The vomited matter consists at first of strongly acid food; if repeated, it is usually mixed with bile. Highly acid alimentary vomiting at the height of a gastralgic attack is strongly indicative of ulcer; but hematemesis is the only *vomitus* at all distinctive, and in association with the characteristic pain and tenderness becomes the positive sign of gastric ulcer. In the absence of hematemesis, melena may supply the necessary evidence of hemorrhage. The absence of either of these signs, however, cannot be accepted as proof of its non-occurrence. Small bleedings do not usually cause vomiting, and a careful examination of the feces is generally neglected. Yet these small hemorrhages, insignificant in themselves, may lead, through constant repetition, to the gravest anemia.

Hemorrhage is variously recorded as occurring in from one-half to four-fifths of all cases. When slight it may appear in the vomit as fine bloody streaks, or small reddish-brown flocculi, depending upon the time it has been subjected to the action of the gastric juice. It is, however, more commonly profuse, and so bright in color that there is no doubt of its arterial origin. The quantity is sometimes so large and so quickly poured out by the eroded vessel that syncope results, and death supervenes before the blood can be ejected from the stomach. Sometimes the blood gradually oozes from the ulcer and collects slowly, remaining in the stomach some time before it is ejected. It then becomes mixed with food and much changed by the action of the gastric juice, appearing as reddish-brown granular masses, or even assuming the well known coffee-ground appearance. Sometimes the blood is not vomited, especially when the hemorrhage is small, but passes into the bowel and is so decidedly changed that it escapes detection. When in considerable quantity it gives to the feces a tarry offensive character which, with preceding symptoms of shock, is sometimes the first indication of gastric hemorrhage. Epigastric fullness and pulsation, with flashes of heat and unaccountable restlessness, are frequently precursors of hem-

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orrhage, but serious and even fatal bleeding may occur without premonitory symptoms.

Perforation occurs without distinctive premonitory symptoms, although the plastic peritonitis caused by the ulcerative process reaching the peritoneal covering and causing adhesion of the stomach wall to the adjacent organs manifests itself occasionally by localized pain referred to the organ involved. More frequently disordered function in the involved organ leads to the suspicion that the ulcer has extended beyond the stomach. This complication may involve any of the organs in the upper abdominal or thoracic cavities, and is productive of a train of general and special symptoms the consideration of which is beyond the scope of this paper. Perforation into the free abdominal cavity occurs less often, and usually without warning. Traumatism, vomiting, or the distension of the stomach by food or gas acts as exciting causes; but the accident may occur when the stomach is at rest. Sudden and severe pain in the epigastrium is generally at first indication of perforation. This pain soon becomes diffused, and is followed by vomiting, tympanites, hiccough and collapse. Recovery sometimes takes place; but usually death occurs rapidly from shock, or in the course of a few days as the result of a general purulent peritonitis.

The only physical signs of value in gastric ulcer are the extreme tenderness on firm pressure over the site of the ulcer, and the presence of a smooth, indurated tumor, discovered by palpation and percussion, usually in the situation of the pylorus. If the ulcer is situated apart from the pylorus and is of long standing, its thickened base may sometimes be felt as a smooth disklike mass to the left of the median line. The tumor formed by the deposition of inflammatory exudate at the point of adhesion of the ulcer to adjacent organs can sometimes be made out by palpation and percussion.

The general symptomatology presents nothing distinctive, and is usually that of the gastritis or chloro-anemia which are so frequently associated with ulcer as etiological or complicating factors. The tongue presents no characteristic appearance. It is frequently observed to be quite clean or only slightly coated. It sometimes presents a strikingly red, either smooth or furrowed surface. Obstinate constipation is the rule, and is perhaps due to the small amount of food taken and retained, although there may be inhibition of intestinal peristalsis through reflex nerve action. Hemorrhage frequently causes colicky pains and diarrhea, with stools that are dark, tarry and offensive.

There are no distinctive clinical signs. Oligocythemia is the blood condition usually present after repeated hemorrhages, and digestive eucocytosis has been found absent in some cases. Hyperacidity of the astric juice, due to excess of HCl. is usually present, but may decrease

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if the course of the ulcer is prolonged. The acidity of the urine is decreased, its reaction is frequently alkaline, and the chlorides are either greatly reduced in amount or entirely absent. The epigastric surface temperature is elevated, even above that of the axilla.

Cachexia, if at all present, develops late in the disease, and is due rather to the great debility and extreme anemia resulting from repeated hemorrhages and inanition than to any pathognomonic blood-changes. The face assumes an earthy pallor and is drawn and haggard, presenting the *facies abdominalis* which some regard as typical of gastric ulcer. Fever is absent, and emaciation usually not great, although the amount of food taken and assimilated is limited because of the pain and vomiting. When dyspeptic symptoms are prominent, emaciation is sometimes extreme.

In simple uncomplicated ulcer the functional efficiency of the stomach is not greatly affected. Motility is not much impaired, there is no decrease in absorption, abnormal bacteriological signs are absent and there is no variation in digestive activity excepting that resulting from hyperchlorhydria. Such a case may recover without subsequent impairment of the digestive function. As healing progresses the pain is no longer constant, but is felt only during digestion or after fatigue and excitement. The tender points become less sensitive and finally disappear. Vomiting becomes less frequent as the pain subsides, and finally ceases. Hemorrhage is usually the first symptom to disappear, and recovery from the anemia, when simple, is generally very rapid.

When ulcerative adhesion has taken place or peristalsis is affected by reflex action the motility of the stomach is interfered with and dyspeptic symptoms supervene. Sometimes cicatrical tissues impinge on terminal nerve-filaments in the ulcer scar, and gastralgia remains as a permanent affection. Adhesion to neighboring organs, and deformity and pyloric stenosis from extensive cicatricial contraction, frequently permanently compromise the functional efficiency of the stomach, and chronic invalidism results.

Discussion:

Arthur E. Thomas, M. D.: Ladies and gentlemen, it seems hardly necessary to consume time in the discussion of such papers as we have had presented, they are so complete and accurate; however, there are always details which must necessarily be omitted in the paper, and which may be developed in the discussion. The paper entitled "The Symptomatology of Gastric Ulcer," which I am scheduled to discuss, I desire to compliment very highly. The essayist has left very little for me to say.

In the first place, his outline of the disease is very accurate, but on account of the complications which, under many conditions, accompany gastric ulcer, he has necessarily omitted some few things, which,

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perhaps, are important. In speaking of the diagnosis and of the overlooking of gastric ulcer by the practitioner he may, perhaps, have conveyed to you the idea that gastric ulcer was hard to diagnose; this, I think, he did not intend to say; according to the best and most reliable statistics, a large number of gastric ulcers occur and heal spontaneously, the scars being afterward found in the post mortem examination; in addition thereto, we find the open ulcer, the active ulcer, at the *post mortem* examination. Some authorities state that three per cent. of all *post mortem* examinations indicate that the person has, or did have, gastric ulcer, while others claim that the percentage is as high as five. As I have stated, the explanation of this is that ulcer of the stomach often occurs in complication with other gastric diseases, especially in some acute diseases; for instance, I think you will find it very commonly a complication of typhoid fever. There are also diseases of other organs in which gastric ulcer may be a complication, such as certain diseases of the liver. Then, too, certain cases of gastric ulcer become chronic; the person may have had previous ulcers extending through the stomach wall and producing adhesive inflammation at some former time; another ulcer may occur, and new inflammatory product be thrown out, which may cause pressure upon the bile duct, preventing the flow of bile into the intestine. If the ulcer be located in the right place, it is possible for this to occur, and you will have symptoms of bile obstruction and, perhaps, the case will be overlooked so far as the ulcer is concerned, and be diagnosed as some form of liver trouble.

You can go right through the paper very much in the same way, adding to it slightly in certain places, perhaps, but the paper is so complete it is not necessary to do so. Before closing, however, there is one point I desire to call attention to, and that is in regard to physiological leucocytosis. The paper states that there are cases of gastric ulcers, and, if you find a case where you have the symptoms of gastric ulcer complicating any disease, and leucocytosis is absent, I think you ought not to mark it against the evidence of ulcer.

Another point, in regard to the physical signs—there are no physical signs of any value in the diagnosis or symptomatology of ulcer. The essayist said that sometimes we could by palpation or percussion outline the location of the ulcer; now, it has been my experience never to have had a patient who would permit such manipulation—this on account of the pain involved—and I think I could not do it if he would allow it. It would have to be an exceedingly rare case, and the ulcer would have to be very favorably located, and it would have to be one of long standing and have considerable exudate around it. Then, too, from a conservative standpoint, I think it would not be advisable when we suspect ulcer ever to try to outline by physical methods; the two sensitive spots of gastric ulcer, one over the epigastrium as described, and the other near the tenth dorsal vertebra, just to the left of the spine, are the only points we can safely make use of in the way of diagnosis in the physical examination of gastric ulcer.

A. B. SCHNEIDER, M. D.: I have nothing to say excepting in reply to Dr. Thomas' mild and courteous criticism regarding the omission of some of the minor symptoms. The very prudent Chairman of the

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Bureau requested me to limit my paper to fifteen minutes. When I had prepared the first draft of the paper I had ten pages, and the reading of the first page consumed three minutes. Considerable pruning was necessary, and it is possible that some of it was injudicious. It resulted in the omission of all citations and references to authorities, and among these was the authority for the statement concerning the absence of digestion-leucocytosis in some cases. This was cited by Ewing in his "*Clinical Diagnosis,*" and mentioned not as having any special diagnostic significance, but particularly in relation to its bearing on the differential diagnosis between ulcer and cancer, digestion-leucocytosis being usually absent in cancer and supposed to be always present in ulcer; but the fact that it was absent in a number of cases, some ten cases cited, in which a diagnosis of ulcer was confirmed by post mortem examination, would indicate that it is not a reliable sign.

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THE DIAGNOSIS OF GASTRIC ULCER

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So closely allied to the pathology is the diagnosis of any disease that a clear conception in our minds of the true nature of that disease whose existence we are attempting to establish, will render the more intelligible, and with more ease and surety, a proper translation of the manifestations presenting themselves as a result of the presence of the disease. Hence, if we remember that in gastric ulcer we are dealing with a localized area of stomach wall, though it may be confined to the mucous lining only, and appreciate that it is not an inflammation, nor a neuralgia, nor a mere functional mucous membrane disturbance, nor that change and increase of hardened tissue due to malignancy, but a nutritive enervation of localized stomach-area leading up to a local necrosis of the tissue if following out unchecked its natural bent, we can readily appreciate why, somewhere along the line depending upon the stage of progress, local pain and tenderness, vomiting and hematemesis are the cardinal symptoms of this affection.

We will give our attention first to the diagnostic features of the most frequent symptom of gastric ulcer, and the most characteristic when we consider its nature and location—that of *pain*. It is of an intense gnawing, boring or burning character differentiating it from the more neuralgic pain of gastralgia; from the lancinating but less intense and more continuous pain of cancer; from the more diffuse but much less severe pain and tenderness of gastritis; and from the heavy load-like distress of the different functional dyspepsias.

The pain and tenderness are more localized than in any other disturbance of the stomach or neighboring parts, so much so that the most important diagnostic feature of the pain of gastric ulcer is its localization, which I desire to emphasize, amounting as it does to a fixed seat, and located just below the ensiform cartilage, a little to the right of the median line. This fixedness of seat is also diagnostic of the dorsal pain, for the reason that when it is present, as it usually is some time after the onset of the epigastric pain, it is located at about the eighth or ninth dorsal vertebra, to the left of the spine. Contrasted to this positive feature is the fact that in no other disease of stomach or neighboring parts do we find this fixed localization of pain.

Again will the pathology impress us why the next important diagnostic feature of the pain of gastric ulcer is the trio of symptoms pertaining to gastric digestion; severe aggravation of pain following the par-

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taking of food; continuance of the same until the end of gastric digestion; and sudden relief when vomiting frees the stomach from its contents. We notice two other diagnostic points concerning the pain of gastric ulcer, first that while marked relief thus follows, yet some degree of distress usually remains between the severe paroxysms of pain and vomiting; and lastly that severe aggravation of pain and tenderness occurs from pressure and in fact from any irritation within or without.

Of the painful affections of the stomach, gastritis should be differentiated by the other accompaniments of a neurotic condition which are usually evident, while with ulcer a run-down condition more of blood or nutrition, and suggesting anemic or chlorotic tendencies, is more in evidence. The pain of gastralgia lacks the boring, gnawing character of ulcer; the tenderness and pain are diffuse not localized; they do not have the marked aggravation from partaking of food, on the other hand they are more apt to be relieved by food; while in the exceptional cases where food does cause pain in gastralgia, there is not the marked relief by vomiting which we find in ulcer; the pain and tenderness of gastralgia occur in irregular paroxysms; they are rather relieved by pressure; while between the paroxysms there is complete relief.

The pain of cancer of the stomach has not the boring, gnawing character of ulcer, but is more lancinating in character; it is less intense, but more steady and continuous; it is less localized, as it not always corresponds to site of lesion; it is not so much dependent upon gastric digestion, which is the most important diagnostic feature of the pain of cancer, hence it is much less aggravated by the taking of food, is not relieved at the end of gastric digestion, and much less relieved by vomiting; the cancer pain occurs more irregularly, and there is more distress between the paroxysms than in the case of ulcer.

The pain of chronic gastritis, or, if preferred chronic gastric catarrh, is unlike that of ulcer, occurring as a diffuse distress, much less severe and not aggravated by the food; while the usual symptoms of stomach indigestion; mucous, gaseous and the like; their amenableness to regulation of diet and other treatment; together with absence of the characteristic vomiting and hematemesis of ulcer will serve to differentiate it.

The acid-burning character of the pain of hyperchlorhydria coming on two or three hours after the taking of food; the frequent water-brash and pyrosis, as well as their relief by nitrogenous food and alkalies; the exclusion of the marked localized pain and tenderness and of their aggravation by food will, with the absence of hemorrhage, serve to differentiate this hyper-acid condition of the stomach.

Pain, when severe, might be confused with biliary colic, but the more intense and colicky nature of the latter, starting from the right

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side and extending to the left; its sudden onset, and especially its onset while the patient is asleep; its sudden termination; the presence of jaundice with other accompaniments of the biliary tendencies will differentiate it.

The diagnostic characteristics of the vomiting of gastric ulcer, constituting the second cardinal symptom, will be appreciated from its pathology, for a stomach with an ulcerous opening in its internal coats will not bear irritating food, drink or drugs, and consequently it quickly ejects any of these, and in the same condition as when taken into the stomach; neither will it bear an acid gastric juice excited by these, nor blood poured into it from its vessels, nor pressure or other irritation applied from without; the vomiting storm, thus aggravated, is very quick to gather, severe while it lasts, and quickly over after the stomach has rid itself of its offending irritant. In other words, so far as vomiting is concerned, the ulcer is quiet when let alone, but growling always when molested.

Not so with cancer of the stomach, for its vomiting will take place when not aggravated by the stomach-contents, as it has not that resulting relation to the taking of food, and consequently it usually comes on irrespective of the same; when food does produce vomiting, there is not that relief which is afforded by the vomiting of ulcer; and in this feature of no relief by vomiting lies an important diagnostic symptom of cancer of the stomach; cancer vomiting occurs irregularly; it may not occur for days, but oftener if its location at pylorus or cardia favors; when it does occur it is often in very large amount, and partaking of the character of dilatation of the stomach; the nature of this cancer-vomiting is never of the comparatively fresh contents of the stomach, as in ulcer, but more of undigested food, which has lain in the stomach for some time, and particles of which have undergone decomposition; there may be changed blood debris, or mucus, and an offensive odor to the vomited matter in general. Thus we see that the vomiting of ulcer is not on account of the ulcer primarily, but from irritation acting locally upon the ulcer, and due to offending matter introduced into the stomach or to irritation applied without; the vomiting of cancer, on the other hand, does not owe its existence so much to extraneous irritation, as that it is usually more directly concerned with the local condition of the cancer itself or due to the more profound cause of the general cachexia.

The infrequent vomiting of chronic gastritis and the neurotic vomiting of the different neuroses, considered in the light of the presence of other well defined symptoms of their own, as well as of the absence of the characteristic symptoms of gastric ulcer, need not be further considered.

The third cardinal symptom of gastric ulcer—hematemesis—is the

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one symptom of the trio of pain, vomiting and hematemesis which, when present, most surely serves to indicate the disease, inasmuch as it is a characteristic hemorrhage, in that it is generally sufficiently copious to cause the stomach to eject it unchanged in color or consistency probably due to the process of ulceration opening up the coats of the blood-vessels of the affected stomach-area; even when smaller in amount and remaining in the stomach for some time, it rarely assumes the typical coffee-ground character of malignant disease, but is changed rather to reddish or dark-brown clotted masses. While more profuse than in cancer, the hematemesis of ulcer is less frequent; it comes at decided intervals, and after an attack of severe hemorrhage, in which the loss of blood may be considerable, has been relieved, a long interval may elapse before another loss of blood; it comes more with the nausea and vomiting; it is often accompanied by the presence in the stools of the tarry blood of malena, and rarely the latter may be the only manifestation of hemorrhage; finally an important point of diagnosis is that the hematemesis of ulcer appears when the general condition of the patient seems not much impaired.

The hematesis of malignant disease on the other hand is more frequent, appearing sometimes as a series of small hemorrhages with short intervals between; it is rarely profuse; and these characteristics are in turn explained by the bleeding coming from the very small vessels of the sub-mucous plexus, or from the still smaller vessels of the mucosa covering the cancer; the nature of the hemorrhage is usually of the typical coffee-ground character, from the changes the blood undergoes in the stomach; it is often mixed with food, mucus or gastric juice; it does not occur with nausea and vomiting; and it most commonly occurs after cachexia has permanently shown itself; malena is less frequent, as if the hemorrhage into the stomach was not sufficient for the blood to escape into the intestines.

Though hematemesis is a frequent symptom in cirrhosis of the liver there should be no confusion between this disease and gastric ulcer on account of the diversity of other symptoms, which is so apparent as to need no further attention; nor should we be deceived, on account of the absence of other symptoms, if we ever meet with stomach hemorrhage Austin Flint described as "idiopathic."

The consideration of hematemesis as a diagnostic symptom of these diseases we have been considering should carry with it the certainty that we are dealing with a genuine gastric hemorrhage, in which the bleeding originates in the stomach, or technically, a gastrorrhagia; and with care it is always possible to exclude the vomiting of blood which has found access to the stomach from other organs.

When duodenal ulcer does not owe its existence to the patent cause

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of extensive surface burns, it should be differentiated from ulcer of the stomach by its greater frequency in men than in women, except in the case of burns, when the opposite is true; by its occurrence in young child life; by the early and severe emaciation in lieu of the chlorotic or anemic state of gastric ulcer; by the occurrence of pain two or three hours after meals, rarely located in the back, but very frequent and located more to the right and aggravated by lying on the right side; by the delayed vomiting, three or four hours after meals, which bears no relation to gastric digestion, and in which no free hydrochloric acid is found; by the rare vomiting of blood and then only when hemorrhage is sufficient to allow blood to pass into the stomach; but by its common malena; and by this duodenal form of ulcer tending so often to perforation.

Thus far we have considered the diagnosis of gastric ulcer by an analytical comparison of its trio of cardinal symptoms, with like symptoms occurring in other diseases, for the reason that it is upon these symptoms that the diagnosis very closely hinges, though it may be reinforced by due attention to a few additional features which I will merely touch upon.

So far as the indication of the chemistry of stomach contents is concerned, the presence of hydrochloric acid in excess in ulcer and its absence in cancer is an important diagnostic symptom; and notwithstanding it is found in a small percentage of cases of cancer, its presence in excess and especially in the large amount usual in ulcer is very strong evidence that the disease is not cancer.

The factor of a good appetite and usually an insistent demand for food on the part of the ulcer patient, contrasted to the usual anorexia of cancer, has come under the notice of the writer and has some diagnostic value.

One should not forget the ulcer and cancer age-line of respectively before and after approximately forty years of age, though ulcer appears more often after than does cancer before that age.

Tumor is not present in ulcer, but is present in cancer and in cancer alone, occurring in no other disease; it is one of the most diagnostic symptoms of cancer, occurring in the proportion of eighty per cent of the cases.

There is absent in ulcer that characteristic cachexia which appears sooner or later in cancer, but lacking in all other diseases, and which differentiates the general condition of the cancer patient from the more innocent mal- or, rather, sub-nutrition or anemia of the ulcer patient whenever an abnormal general condition of the latter is present, which is the rule proved by its rare exception.

While the diagnostic features which indicate gastric ulcer are those of its well-developed stage, early symptoms are at least suggestive, and it

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is here that the intuition of the physician should have full sway, for in this disease, as in every other, the earlier the diagnosis can be made the more advantageous to the patient and satisfactory to the physician. The earlier the stage of gastric ulcer in which the patient comes to the notice of the physician, the more will the latter be obliged to rely upon the presence of gastric discomfort in forecasting the malady threatening his patient. An alertness in appreciating the epigastric uneasiness of the digestive disturbance of which the patient first complains, amounting to a tightness or weight which is aggravated every time food is taken, as if the latter stopped and went no further than the distressed spot, as well as in appreciating its persistence notwithstanding dietetic or other treatment, will enable an earlier diagnosis than if the true nature of the affection were not suspected until the advent of the cardinal symptoms themselves.

Such appreciation of early symptoms and condition of patient and their portent, with careful analysis of the characteristic symptoms as they present themselves in the later and more marked stage of the disease, will lead one in the great majority of cases to a positive diagnosis of gastric ulcer.

Discussion:

Wm. Wallace Gilbert, M. D.: In presenting this paper the doctor has certainly covered the field most thoroughly, especially as far as the typical ulcer is concerned.

The great trouble is now, and has been, to recognize an ulcer of the stomach in an early stage when treatment is more effectual, when the symptoms are more masked, rendering differentiation more complex, and, before the three cardinal characteristics of pain, vomiting and hematemesis referred to, are present, or even any one of them present. When the uneasiness or distress after taking food, commonly called by the patient dyspepsia, is the only symptom, this is the time when, if a diagnosis of ulcer could be positively made, much more rapid cures would result. It is in this stage that the essayist truly says the diagnostician will often have to be guided by his intuition

A patient some time ago called attention to a simple method of differentiating incipient ulcer from dyspepsia. She came complaining of ulcer of the stomach, and when asked how she knew it was ulcer, said that it must be something serious as, when quite a girl, she was troubled with distress after eating and that when she chewed pepsin-gum it always relieved it at once, which after some treatment became quite well. In recent years she again complained of great uneasiness immediately after eating. This time the gum failed to relieve, the uneasiness lasting until stomach digestion was completed. The last trouble had continued until vomiting of blood suddenly proved the positive nature of the disease. It is hardly wise to recommend chewing-gum, especially to the ladies, but the use of pepsin may be of diagnostic value.

A peculiar fact that has been noted, accompanying gastric ulcer, is the apparent healthy appearance of, possibly, about fifty per cent.

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of the patients; that is, before any repeated or severe hemorrhage has occurred, which will naturally cause anemia.

One particular diagnostic procedure the essayist has failed to mention, and this failure is to be praised unless in calling attention to it he condemns at the same time; that is, the use of the stomach-tube or pump. If this instrument is used, too much care cannot be employed. Its use has, oftentimes caused chagrin to the operator and not infrequently censure, because of the hemorrhages, or even fatal perforations that have followed its application. Then again, it has been used with marked success by some, with which to secure the stomach contents, especially after giving the patient a test-meal, and this with never an accident. However, its usefulness can safely be limited to hospital practice; rarely in private work.

In addition to the character of the pain and vomiting, particularly after meals, that have been mentioned, one valuable peculiarity for diagnostic purposes is relief from both these symptoms by certain postures that the patient involuntarily assumes. Or, it may and is often voluntary. The posture thus assumed being not only an aid in diagnosis of ulcer, but, many times, indicating the seat of the lesion.

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TREATMENT OF GASTRIC ULCER

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Although, for various reasons, which are obvious, prophylactic treatment of gastric ulcer is, in very many cases, impracticable, yet it would seem that, if we bear in mind the etiological factors involved, we should most carefully advise those who are especially exposed to the causes of the disease so to order their lives, hygienically and dietetically, that the individual index may be strengthened as much as possible.

Ewald says that, "the failure of due proportion between the acidity of the gastric juice and the constitution of the blood is always necessary" for the development and progression of gastric ulcer.

Leube, in other words, gives a similar opinion: "The simultaneous appearance of two factors, anemia and an abnormal degree of acidity of the gastric juice, must be assumed in chronic ulcer of the stomach."

Recently a bacterial origin of ulcer has been suggested.

But, however the origin of the disease is explained, it is justifiable to admit that some abnormal constitution of the blood is the chief predisposing cause of ulcer, that this condition is frequently observed among the chlorotic and anemic, among women whose menstruation is irreguler or suppressed, and among the tuberculous and syphilitic.

Now, inasmuch as it is well demonstrated that the per cent of ulcer found among persons dying from all causes is from five to ten, that women are more subject to the disease than men, as six is to ten, and that it occurs more commonly between the ages of twenty and forty it would seem that if consulted by a chlorotic woman of twenty-five years, the physician should be keenly alive to the possibility of the development of ulcer of the stomach, and should institute preventive treatment accordingly.

Such treatment would include not only the adoption of the well-known measures adapted to modify the predisposition, but also such general and specific remedies as each individual may seem to require.

In the general management of the disease it is admitted that the first and most important consideration is to secure perfect rest, at least during the continuance of the acute symptoms.

Now, it seems to me that, as practitioners, we fail to explain to our patients just what we mean by perfect rest, and, therefore, frequently fail to secure it. Perfect rest means something more than simply lying in bed. It means that everything should be done to secure physical repose and mental tranquillity. Perfect support in a good bed, the positive

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assurance of safety consequent upon a favorable prognosis, careful regulation and adjustment of diet, control of pain and the avoidance of every possible disturbing influence. These are all essential to perfect rest. The patient should see no visitors, should not be talked to or allowed to talk, and should be examined and moved as little as possible, until the acute symptoms subside. In other words, to secure perfect rest we must utilize every possible means to assure comfort. The importance of giving a favorable prognosis in disease is emphasized in a recent paper of Dr. Henry F. Walker, of New York, on suggestion. Probably in no class of cases is a reassuring opinion of more importance than in ulcers of the stomach, in which almost invariably dyspeptic symptoms are so demoralizing and the occurrence of hemorrhage is so alarming. Not infrequent recoveries, and the fact that fatal hemorrhage is not common, will fairly justify such an opinion even in the minds of those who may be skeptical as to its therapeutic value as a psychical influence. Again, the patient must understand, as the disease is essentially chronic, successful treatment depends upon prolonged rest and the most exact observance of rules and regulations. It may be very difficult to enforce demands, but considering the nature of the disease, we can do no less than to make them.

Diet is the next consideration. If we would successfully regulate the diet of the dyspeptic, the anemic and the chlorotic, we should probably see but few cases of ulcer. Now, it seems to me that after all the talk of scientific feeding is done, very few arbitrary rules can be prescribed. Generally, I believe in freshly, thoroughly cooked and well-seasoned food, of generous variety, in meals consisting of not more than three dishes, including bread and butter, in the free use of plain, pure water between meals; and I think the meals should be taken practically, not absolutely dry; and I do not advise any alcoholics. I avoid all soups, except as soup with bread is taken as a meal by itself; I order thorough mastication and slow eating, and I advocate one-half hour's rest before and after each meal. If the meals are large, I say three; if they are small, four in twenty-four hours. Such a diet may be greatly varied, and may include most every dish of reasonable repute. Unfortunately, those who are to become the victims of ulcer are usually so situated in life that cultivation of hygienic necessities is practically out of the question. These people are apt to have poor teeth with which to eat poorly cooked food in very limited time. But, unquestionably many would and could do better were they properly instructed.

In an acute case in which either vomiting, hemorrhage, severe pain or tenderness leads to the suspicion of a possible perforation, total abstinence from all food should be practiced for from one to three days, according to the persistency of the symptoms.

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During this period thirst may become a most urgent system. For its relief, four to six ounces of plain water, to which is added five to ten grains of bicarbonate of sodium, may be injected into the rectum every four to six hours, and teaspoonful doses of the same solution may be allowed by mouth at hourly intervals. With lavage, which is sometimes recommended, I have had no experience. As the symptoms subside the amount of water given by mouth should be increased and food gradually introduced by rectum. Nutrient enervata will comfortably sustain. the patient for a few days to a week, after which time I have found it generally practicable to begin stomach feeding. Cereal teas, milk and lime water, and buttermilk to start with, for a couple of days, will usually preface the way nicely for the successful use of clam-broth and later chicken-broth, beef-juice, egg-water, peptonized milk and bland gruels.

These foods must be given in small quantities, one ounce at first, the patient being told to hold each mouthful in the mouth long enough before swallowing to permit of free admixture of saliva; and the interval of feeding should not be less than two hours. Gradually, if none of the acute symptoms return, the quantities of food and the intervals of feeding may be increased.

Possibly in four weeks we may get the patient on a semi-solid diet. After that time the diet should consist of the simplest and most nutritious foods and should be composed mainly of cereals and soups, custards, and blanc-mange. In one case a craving for chocolate at this stage gave me a hint for a most useful food, and a cup of chocolate morning and afternoon proved most palatable and apparently beneficial.

Before solids are permitted, eggs, oysters and stewed sweetbreads or tripe should be advised. Solid food may be of a generous variety in simple form and combination, but certain dishes should be forever tabooed, such as all foods containing seeds, all tough meats and coarse vegetables, and anything that is likely to prove mechanically irritating, such as crusts of bread and the like.

Under the head of medicinal treatment, it is important to inquire how shall we administer our medicines? Of course, unless the symptoms contra-indicate, I give them by mouth. And even when the stomach is very irritable, and when vomiting and hemorrhage are intermittent, the remedy can sometimes be taken when given with a bit of ice. But excessive irritability, continuous vomiting or hemorrhage, will practically necessitate the use of the hypodermic syringe.

What remedies have we? Bearing in mind the abnormal constitution of the blood, which predisposes to ulcer, and remembering the possibility of cancerous development, it would seem that no remedy covers the premonitory, the acute and the consecutive symptoms so well as Arsenicum. I prefer the iodide. Under this drug, well indicated, I

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have seen in three well-marked cases, the progress of the disease checked, recurrences limited and controlled, and a practical cure established. In each case the long-continued administration of this in the third or sixth trituration was exceedingly well borne.

In an old patient, in whom a tendency to degeneration is well marked, phosphorus may be a more suitable remedy.

I have found Argentum nitricum useful in modifying the one symptom of inordinate belching of gas; but I have been disappointed in its effect upon the disease in the chlorotic subject, for whom it has been so steadily recommended.

So also with Uranium nitrate. This remedy has seemed to act satisfactorily only while the symptom of excessive urination has been present.

In a very recent case I have had great satisfaction in the use of Carbolic acid and Ammonium carb. I was lead to the use of the acid because of the success in the treatment of superficial ulcerations with it and alcohol. Allen says that Carbolic acid has been found useful in cancer of the stomach. Great prostration and symptoms of paralysis may be considered as two great indications for its use.

Ammonium carb. was suggested to me by Dr. Henry M. Dearborn, in a paper in which he emphasized its usefulness in scorbutic conditions. When generally indicated, this drug will, I think, be found very useful in gastric ulcer.

The indications for such drugs as Kali bich. and Hydrastis are well understood and need not be dwelt upon. In their own sphere of usefulness they are unrivaled.

Ipecacuanha continues to be the drug for nausea and vomiting, with or without bleeding; but if belching is the chief feature Hamamelis covers the case up to the point of excessive hemorrhage. One need seek no further. But if hemorrhage is great and collapse threatens, I should and would give a hypodermic of morphine, and would apply heat or cold to the spine.

For the pain Belladonna or its alkaloid will usually suffice. Here also the application of heat or cold may be comforting. In one instance a spray of sulphuric ether upon the pit of the stomach gave great temporary relief.

I have found continued depression of the temperature a symptom of gastric ulcer, especially in the case in which Carbolic acid proved so useful. I have taken the depression as an indication for Antipyrin when pain was a marked feature. One one-hundredth of a grain has been the dose; and it has acted favorably, not only upon pain, but also upon the temperature.

In any very severe cases of gastric ulcer, when the symptoms resist

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the physician, the surgeon should be introduced. For, in excessive hemorrhage, not only may it be necessary to apply a ligature to an arm or leg to transfuse or infuse, but also direct operation upon the ulcer may be demanded. Such operation has been successfully done, and in perforation we have nothing else to offer.

DISCUSSION:

W. B. HINSDALE, M. D.: Taking the gross pathological condition as a guide in gastric ulcer, as in all other ulcerative processes, we must say that it is strictly a surgical disease. Were the lesion within easy access, the treatment would, according to the methods now in vogue, be topical, antiseptic, curettement, with mechanical means or hot water to control bleeding. Since the ulcer is in a closed viscus and the present limitations of surgical means rather contra-indicate opening the abdomen and stomach unless special emergency arises, it must be treated mostly as a medical disease. The essential point to be uppermost in mind is that it is not a primary, but a secondary disease. As Dr. Knott has made clear, it usually follows inanition, exhaustion, blood impoverishment, bad hygienic and dietetic conditions. What the doctor says about prophylactics I would emphasize. Any impoverishment of body likely to lead to the particular disease under consideration, tuberculosis, cancer, tumor or any other degenerative process should especially engage the attention of the medical attendant, and means should be taken to ward off such sequels; even if the primary predisposing cause does not yield readily.

Dr. Nott's definition of rest is excellent, and I believe the best I have ever heard.

In regard to diet, I would endorse his suggestions in the main as very practical. Pre-digested milk is frequently very beneficial. Perhaps the most difficult thing to accomplish in regard to feeding is to hold the patients to a selected diet long enough after the disease seems to have been cured. It is also sometimes difficult to change from a liquid to a semi-solid and solid diet.

To my mind the homœopathic remedies are, of course, the ones to be used. The most that a prominent old-school authority says he hopes to get from his drugs is, not that the ulcer is affected by them, but possibly the gastric catarrh may be; but he doubts even that.

Pain should not be allowed, of course, to exhaust the patient, but hypodermics of morphine had better be used as sparingly as possible. It may be a question whether it would not be more humanitarian to permit a patient to go without its temporary, soothing effects than to be a life-long morphomaniac. The remedies that are suggested in the paper are, of course, the main ones, but routineism should be especially guarded against in a disease with so many contributing and individualizing factors. I have found, when lavage is permissible, that washing out with a solution of *hydrastis*, occasionally, seems to be very beneficial.

As the paper suggests, owing to the fact that gastric ulcer affects, more frequently, a class of people who cannot avail themselves of the right kind of environment and treatment, it is a disease of somewhat

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grave significance. But with good surroundings, good nursing, the imperative injunction to rest in Dr. Nott's effectual way fully carried out, reasonable reactive vital capacity, a reassuring doctor, and the remedy that is selected upon suggestions gathered from the history, present systemic status, and the individuality of the patient, the outlook is good. When surgeons can operate with the same impunity upon the gastric mucous membrane that they can upon the skin or rectum, they may shorten the period of duration, preclude the risks from infection and be of every-day use to the physician in internal medicine.

S. H. Aurand, M. D.: It has been my province for some time to have a great many cases of gastric ulcer to treat in our clinics, and I find that these clinical cases are of the very worst class. You cannot prevail upon them to take the necessary rest which has already been outlined, and which is of such vast importance in the treatment. I believe that rest is the first necessary injunction to be placed upon the patient suffering with gastric ulcer. I therefore try to give my patients absolute rest by putting them to bed, and the stomach absolute rest by allowing nothing to enter it but water. With my private patients, and also with my clinical patients, so far as possible, I allow nothing but water to be taken into the stomach for the first week. All the food that is necessary is taken by means of enemas. Very little food is necessary in the majority of these cases for the first week; for that matter they could get along very well without any, unless much emaciated. I like what Dr. M. B. Blouke, of Chicago, calls the natural lavage for the stomach much better than passing the tube. He recommends having the patient take it in the morning one hour before breakfast, or before rising, before they are up and about This consists of taking one-half pint of water as warm as can be drunk, and gradually increase to one pint, or all that the patient can comfortably take. They should then by the contraction and relaxation of the abdominal muscles agitate the water in the stomach for from five to ten minutes, first with full inspiration and then with complete expiration. The patient should then be instructed to lie on the right side to assist the water in draining into the bowels. This process should be repeated every morning.

Now, with regard to the remedies. I believe, as has been suggested, that *arsenicum* is a capital remedy for gastric ulcer, but I believe that all remedies should be prescribed strictly in accordance with the homœopathic indications. If the pathology is traced back to some general disorder, especially with the blood, there is no other remedy that would be as suggestive as *arsenicum*. I find, however, that arsenicum works best with the *arsenicum* patient, and the *arsenicum* patient has the *arsenicum* appearance, which is a pale, anemic, drawn or pointed look, generally nervous, restless and fearful, wants water but drinks little at a time. *Argentum nitricum* is a splendid remedy, also, but when this drug is indicated the patient has a vastly different appearance. The skin is dark or brown, and the face has a wrinkled and aged appearance, the stomach bloats and the gas is expelled with great force, when water is drunk the patient feels it gurgling clear through the intestinal canal. *Baptisia* is a good remedy when there is

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much apathy and general debility, foul breath, filthy mouth and brown tongue. *Pulsatilla* is one of the drugs which produces catarrh of the mucous membranes, which goes rapidly on to ulceration. I have found this remedy to act splendidly in the peculiar *pulsatilla* disposition, and especially if there is a complication of uterine difficulties. I must not forget to mention *hydrastis* in this connection, when the tongue is furred with a yellowish coating, bad taste in the mouth, belching and no appetite, stools may be mixed or covered with mucus. The *antimonium crudum* patient has a great desire for acids, the stomach is flabby and much distended, food remains undigested for a long time, the tongue has a heavy white, creamy coating. The *antimonium crudum* patient does not stand heat well; looking into the fire or at the shining sun will aggravate all the symptoms. These are marked symptoms for this remedy, and it will seldom fail you when the above picture is presented.

LEMUEL C. GROSVENOR, M. D.: You were speaking of *hydrastis*. Now, the form of *hydrastis* is *sulphate* of *hydrastia,* that dissolves so perfectly in water and makes *a beautiful straw-colored liquid,* which is so kind to gastric ulcer. The only other remedy I want to suggest is *mercurius,* but there was one other point that was left out, or rather left unfinished: We sometimes have difficulty in knowing certainly in cases of apparent gastric ulcer whether it is a case of gastric ulcer or possibly a case of cancer of the pylorus, as some of the symptoms are similar. Here is a distinctive mark which will settle that perfectly: You know when you have a good meal and it is digesting perfectly you are at peace with all the world; now, in cancer of the pylorus a large proportion of the stomach is in good condition, the peptic glands are doing their duty, the patient enjoys a meal of victuals, and for an hour or two hours he is happy, congenial, etc.; but by this time the food is completely digested so far as the stomach is concerned, and the intelligent little sphincter says to the food, "Now you can pass on." Then comes the trouble. There is no opening of that pylorus, and now comes distress, and by-and-by vomiting, and vomiting of food digested so far as stomach-digestion is concerned; whereas in cases of ulcer of the stomach immediately after eating is the time you have the distress. With this thought in mind you can diagnose almost certainly between gastric ulcer and cancer of the pylorus.

J. B. G. CUSTIS, M. D.: I just want to say a word about *hydrastis*. It is a medicine that formerly disappointed me many times, especially when I waited for the yellow coating on the tongue, of which the doctor speaks. I do not wait for that any more. The white coating mapped similar to that of *natrum muriaticum* is characteristic of *hydrastis* when we have a "goneness" at the pit of the stomach. Remember that "goneness," with large, flabby tongue with white coating that you can see through, is an indication for *hydrastis* in distinction from *sepia,* which covers the same "goneness," but with a dry tongue. I have used *hydrastis* when such symptoms occur. Yellowness is a characteristic of the discharges from the throat, mouth or stomach, and not of the tongue coating. I have used it in the 30th trituration, but the 6th gives good results, especially in so far as it sharpens the appetite.

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GEORGE S. COON, M. D.: There is one point I would like to bring up here. I am interested in this subject, because about six weeks ago I had referred to me a patient to be operated upon for appendicitis. The patient was in excruciating pain, and had been suffering for a week. He had repeated attacks, dating over one or two years. He referred the pain to the appendicular region, extending sometimes back into the kidney. It was relieved by nothing; even morphine would hardly give him relief. I recite this case to call the attention of this society to the fact that the pain in gastric ulcer is sometimes reflex, and is not at the cardinal points that have been pointed out in the paper. The severity of the pain, lack of tenderness over the appendix, or anywhere over the abdomen (you could press anywhere over the abdomen, over the stomach, without the slightest pain, showing that pressure upon the pit of the stomach does not always give pain in gastric ulcer), caused me to doubt the diagnosis of appendicitis, and upon a thorough examination of the urinary organs, I excluded also renal colic. In observing the case for a few days, fortunately for the diagnosis, or perhaps we would have missed it, the man had a profuse hemorrhage from the bowels, but no vomiting. Of course, we did not know where this hemorrhage came from, but from the dark grumous character of the blood we knew it came from somewhere high up. A thorough examination of the contents of the stomach, by giving a test-meal, showed that hydrochloric acid was greatly increased, which is a very important diagnostic symptom, pointed out by the paper, in differentiating gastric ulcer. As a rule there are only two conditions which have hydrochloric acid increased. One is gastric ulcer, and the other is nervous dyspepsia. We found the hydrochloric acid increased double in quantity to what it should be, and also found blood-cells with the microscope. The man at this time, although he had not given us the symptom before, told us that a year previous he had a similar hemorrhage, but at no time vomiting of blood. The excess of hydrochloric acid, blood-cells, and profuse hemorrhages made the diagnosis of gastric ulcer positive, but the interesting point about the case is that the pains of gastric ulcer are sometimes reflex and are not at the typical point, or where they are expected. As I pointed out, it was down about the appendicular region. Other interesting features were, the absence of tenderness over the stomach, absence of vomiting, and absence of aggravation immediately after eating.

J. HERBERT MOORE, M. D.: May I ask one question? I would like to ask the Doctor just what he considers to be the local cause of that pain that he found in the appendicular region; that is, was it merely a reflex neurosis or a reflex tissue irritation of the appendix or any other portion of the intestinal canal? I ask this because, in my experience in other conditions, there seems to come many times a reflex pain down in the appendicular region which often sends the patients to the office with the idea that they have appendictis. Why is it that we get this localized pain in this section of the abdomen? Is it due to a mere neurotic condition, or to some other condition of the digestive system? I have found it drive the patients to the office where I have been very positive that the appendix was not affected. Does the Doctor

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consider that pain to have been due to a reflex neurosis or to reflex irritation of intestinal tissue?

GEORGE S. COON, M. D.: I do not know that I can answer that question. Of course, this man had a good deal of gas in his bowels, and there is a possibility that the pain at this point may have been due to the gas and not to the ulcer; but the fact remains that he always did have a pain at that point. Now, there was another point that came up that may have been a complicating condition. The man passed mucus with these attacks, and we thought at one time that the case was one of mucous colic, in which there is very severe pain, often simulating appendicitis, also, but with each attack of pain there is in mucous colic always a certain amount of mucus passed. Now, of course there is a possibility that this man may have had a complicating disease to account for the pain.

As to the withholding of food from the man of whom I speak, apparently food made him no worse. His attacks were more apt to come on during the latter part of the night, after the food should have been digested and out of his stomach. On a complete withdrawal of food began improvement, which would rather indicate, not positively, however, that the pain was probably of a reflex nature. Various authorities on this matter speak of the pain as sometimes being reflex, and referred to regions other than that of the stomach. Of course, I can hardly give a positive answer to the Doctor's question, because no one can tell absolutely whether that pain was due to the ulcer, but as soon as we stopped irritating the ulcer by food the pain began to subside.

W. H. WATTERS, M. D.: In listening to these papers and the discussions on them, I have looked in vain for one thing: that thing is the positive diagnosis, or differential diagnosis, as you will, between cancer and gastric ulcer. In certain condition of the kidney, when we find the kidney diseased, we examine the urine; when we suspect disease of the lungs we examine secretions from the lungs; when we suspect disease of the stomach, why not examine systematically and methodically the secretions from the stomach? In other words, why not give the patient a test-meal, knowing exactly what goes into the stomach, making a careful chemical and microscopical examination of what comes out of it after a given length of time? If we do this we will find in a majority of cases, at least, certain phenomena; we will find, as has been brought out by Dr. Moore and by the last speaker, an increase of hydrochloric acid in gastric ulcer. If we have a malignant growth, we find lactic acid. We find under the miscroscope in gastric ulcer, as in normal stomachs, a certain peculiar form of bacteria, sarcina, which we do not ordinarily get in malignant diseases of the stomach. In malignant diseases, however, it is believed at present that we get one certain micro-organism, the so-called Boas-oppler bacillus, which is pothognomonic of that condition. Therefore, if we find two things, if we find increased hydrochloric acid and sarcina, we can, with a certain amount of assurance, diagnose a non-malignant condition. If, on the other hand, we find no hydrochloric acid, but some lactic acid, and the Boas-oppler bacillus, we can be suspicious, to say the least, of malignancy. I bring this fact up because it is a point we use in our hospital in making a differential diagnosis.

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C. E. House, M. D.: Mr. President, the papers presented cover the symptomatology of gastric ulcer pretty thoroughly. Few lesions present such complex, and, at times, negative symptoms. We have met with success in some cases of gastric ulcer, if our diagnosis was correct, and with failure in others, proved by post mortem. Symptomatology and diagnosis are so intimately associated that it is difficult to speak of one without discussing the other. A few weeks ago a patient of mine ate a hearty breakfast of ham, eggs, potatoes and bread, drank a cup of coffee and a glass of cold water, and in five minutes was dead. Post mortem revealed a round, perforating ulcer of the anterior wall. What were his symptoms? For fully two months previous to the agonizing five minutes that preceded his death he had suffered scarcely an ache or pain. He was a machinist by trade, and had worked continuously during that period. This case dates back somewhat more than two years. He was then thin in flesh, but that was a family characteristic. He first complained of a feeling of uneasiness in the region of the stomach after eating. In a few weeks he described it as a sensation of weight and oppression, with much flatulence present. About the end of the third month he was seized with intense paroxysms of pain, referred to the stomach and accompanied with vomiting, the matter ejected being strongly acid and often mixed with bile. Later, however, the acidity was less pronounced. These attacks would appear at irregular intervals, whether the stomach was full or empty. For weeks at a time he would be free from pain and would eat heartily of any and all kinds of food (contrary to the advice of his physician) only to be tortured again, without warning, by one of those indescribable, agonizing attacks of pain or gastralgia, which was sometimes, but not often, relieved by vomiting.

I would sometimes find him sitting in a chair, sometimes on his knees on the floor, but usually on the bed rolling from side to side, in a state of agony. He never vomited blood, nor was the ejecta of a coffee-ground color or appearance, nor did he pass tarry stools, so far as I was able to ascertain, although I questioned him carefully at each visit. I never found his temperature more than one-half degree above normal. His bowels were regular when pain was absent.

Such were the symptoms of a peculiar case. The walls of the stomach were softened, a thumb could be forced through them without much effort. The mucous membrane presented a washed-out or bleached appearance. This case had been variously diagnosed by different consulting physicians, but it remained for the post mortem definitely to disclose the true character of the lesion.

There are no pathognomonic signs or symptoms of peptic or gastric ulcers. Pain, vomiting, loss of flesh, loss of appetite, tarry stools, coffee-ground vomitus have all been accounted for, but the absence of almost every symptom for weeks at a time when so serious a lesion was present (as in the case just cited) is a factor in the symptomatology of gastric ulcer as mysterious and unaccountable as the X-ray.

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SURGICAL TREATMENT OF GASTRIC ULCER

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The surgical treatment of gastric ulcer is perfectly feasible from a mechanical standpoint, but the difficulty will be at once apparent when it is asked how is such an ulceration to be located?

Indeed, it is difficult and at times impossible to locate the site of a perforation, and many operators have been unable to find a perforation at time of operation.

There seems to be a wide difference of opinion as to the usual location of such ulcers, sometimes they are situated on the lesser curvature, in the region of the pylorus, and are probably more frequently near the lesser curvature than the greater curvature.

The cardia is a relatively fixed point, and great difficulty will be experienced in operating cases when the ulcer is situated at this point. Unfortunately, ulcers are frequently found at this portion of the stomach.

Ligation of the bleeding point is rarely successful, because the tissues are not suitable for ligation and the more extensive operations of resection must be resorted to in all cases. "Gastro-enterostomy has been especially recommended by Kuster, Rosenheim and Doyen when the ulcer is situated on the posterior wall of the stomach. Ulcers situated on the anterior wall of the stomach are particularly suitable for excision."

Perforation of Gastric Ulcer.—Without question surgery offers a great deal in this class of cases, and the earlier the operation is performed the better, even preparing to operate while the patient is in collapse, so as to be ready to go ahead with the operation as soon as reaction begins.

An incision in the median line, from the tip of the xiphoid cartilage to the umbilicus, should be made, and then a careful search for the perforation should be begun. At times the injection of air into the stomach will help locate the perforation. An area of induration will often guide the exploring finger to the trouble. Again, adhesions to other nearby parts will be noticed, and the perforation discovered. Sometimes the finding of the ulceration is of the greatest difficulty, and in many cases is impossible. Before closing the perforation the question arises whether the stomach should be washed out, and it is surely good judgment to waste little time on this part of the work, but to devote a great amount of time and care in placing the sutures and washing out the peritoneal cavity. Too much stress cannot be laid on the thorough-

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ness with which this washing out process should be done. Drainage should always be used. The above words apply to suturing and excision, but it will be found at times that it is impossible to do more than insert a snugly fitting drainage-tube into the wound and pack around with gauze. This method often saves cases, and the resulting fistulæ may heal spontaneously. Still another plan in these desperate cases is to stitch the edges of the perforation to the wound edges, and treat it as a gastric fistula.

Peritonitis, shock, septicemia are the most frequent causes of death after operation of this kind, but it is to be hoped that the surgeon will be given a chance in all these hopeless cases, because by his aid now and then a patient's life may be saved.

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GASTROPTOSIS—ITS ETIOLOGY AND PATHOLOGY

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BOSTON

When I accepted the proposition to write a paper on "Gastroptosis" I happened to have under treatment a case apparently belonging to the category of displaced abdominal organs, and, at the same time, I could recall several more of that nature which had come under my observation; some with fatal ending, of which I am able to state the results of autopsies. These will be referred to later.

For the present it is desirable to define as clearly as possible what is meant by "gastroptosis." Among fifteen authors, including several authorities, I find that six recognize a distinct falling of the stomach, while the rest speak of this rather in the light of a symptom belonging to distension (*gastrectasis or gastrectasia*) of the stomach irrespective of its causes. Rokitanski, an unquestioned authority, as far back as 1861, recognized spontaneous dilatation and falling as distinct from that form which is caused by narrowing of the pyloric outlet from cancer or other causes. Taking these writers in chronological order, Struempel (1886) likewise recognizes this form, adding that it is rare without being caused by stenosis. Stengel, Anders, Hecktoen and Riesman, as well as Salinger, recognize in gastroptosis a form distinct from that caused by pyloric stenosis; while Virchow, without referring to any distinction, throws some light upon what we mostly desire to know; that is, the manner in which histological changes come about (Tumors; Germ. ed. Vol. III, Part I. Pp. 97-123).

Let us first obtain an intelligible description of a case of gastroptosis, which I will abbreviate from some of the authors mentioned, among whom Hektoen and Riesman furnish as clear a description as any (Textbook of Pathology; 1901, Pp. 769-'70).

There are malformations, also complete absence of the stomach, and dislocations of that organ. A more common condition is that of gastroptosis, or Glenard's disease. This is anatomically characterized by "relaxation" of the gastro-hepatic and hepatico-pyloric ligaments, permitting the descent of the pyloric portion of the stomach, generally a part and parcel of the prolapse of the abdominal viscera generally, particularly of the transverse colon, the right kidney, and liver. This is associated with nervous dyspepsia and atony of the stomach; dragging sensations in the back, constipation, or this, alternating with diarrhea; the patient is anemic, and in the latest stages there is pronounced neurasthenia. According to Glenard enteroptosis is the basis of neuras-

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thenia, a view not generally accepted. Bonneret and Charcot thought enteroptosis rather a result than a cause of neurasthenia, owing to lack of muscular and nervous tone.

The causes to which gastroptosis is assigned are said to be: Pressure from corsets; enlarged liver; contracted chest; relaxation of supporting ligaments; the relaxation of the abdominal walls after pregnancies; pressure exerted by tumors or cysts; nervous depression; gluttony is also mentioned, as well as traction exerted by cicatricial and other adhesions.

While this subject of independent gastroptosis is before us, the study of analogous histological changes is worthy of brief attention. In this connection it is well to call to mind certain uterine displacements which, like gastroptosis, were, and, perhaps are now, referred to the most crude and unlikely mechanical causes.

I am unable to discover any very strong evidence that it was suspected by pathologists that there must be some slowly progressing histological changes preceding such displacements, and that these changes are due to morbid conditions, especially of the nervous cell-elements of the tissues themselves. If we continue our analogy of displacements of the uterus by comparing it with those of the stomach, we find at once that the supporting ligaments must be at fault, and when we consider that these ligaments in both instances are derived from the serous membrane, the peritoneum, we ask at once what the histological elements are that compose them. In a general way these are composed of endothelium, basic membrane (stroma), lymphatics, bloodvessels and nerves.

Now, we need only to recall the possible morbid changes in the cellular structure of one or more of these tissues in order to bring before the mind a picture of the changes which enter into the process of displacement of the organs referred to, or of any others.

Roughly speaking, acute, subacute or chronic inflammations explain the process to a certain extent. It is not to be supposed that one of the component tissues of the serous membrane could undergo inflammatory and degenerative changes all by itself without affecting the others of which it is part and parcel. When these degenerative changes have occurred, the cellular structure broken up, and the nerve-elements paralyzed, then it is easy to see how an organ which these membranes are intended to support, may become displaced.

When degenerative changes have occurred, and the supporting power of membranes is gone, it is then time to explain gastric or uterine ptosis by the aid of mechanical causes. For the present let us allow our attention to be concentrated upon morbid tissue changes to explain the falling down of organs, rather than at once to seek for them in the realm of mechanics, such as pressure, lacing, tumors, etc.

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The tendency to ascribe many physiological and pathological processes to mechanical causes is very noticeable. Bloodpressure and stimulation are too often asserted as causes where these lie much deeper, and should be searched for by the physician who, in his turn, is to search for remedies outside of surgery, mechanics and hygiene. Concerning this treatment suggestions will be made later.

We now come to the kindred and important subject of *gastroptosis in consequence of dilatation, gastrectasis or gastrectasia.* This is by far the most common cause of falling of the stomach, chiefly in consequence of its immense dilatation. It is, however, not to be understood to be a very common pathological state, for it is, on the whole, of rare occurrence.

Of the large number of authors consulted in regard to this subject, there are ten who do not appear to recognize gastroptosis as an affection of the stomach distinct from dilatation. To this form, referred to by all authors as dilatation, (gastrectasis or gastrectasia) we will now give brief attention. It is not to be required of me to furnish a detailed compilation of all that has been written; but merely to give an outline embracing the salient points of this remarkable affection. All authors consulted agree that dilatation is very often caused by obstruction of the pylorus or by a narrowing of its lumen by cancer or by cicatricial contraction after ulcerative processes set up in it, as, for instance, after phlegmonous gastritis. This mechanical obstruction at first causes increased effort on the part of the muscular coat of the stomach to propel its contents, resulting in hypertrophy of the same. In the course of time the expelling power of the gastric walls slackens, ingesta begin to accumulate, and, finally after months or years, a thinning or atrophy of the fundus takes place, along with a sagging down of the whole organ, which may reach to the pubis. But other sources of dilatation are recognized in the absence of pyloric stenosis when the dilatation of the stomach must be attributed alone to the insufficiency of the propelling power of the organ without mechanical obstruction.

This most important pathological distinction has already been referred to while speaking of the condition described as gastroptosis. It is also admitted that chronic gastric catarrh is the most common cause of gastrictasia, by weakening of the muscular power. The walls of the stomach may be either hypertrophied or atrophied, and especially in the latter case the organ may reach an enormous size, covering the other abdominal viscera, and containing many quarts of fluid. The stomach may be said to be dilated when it contains from fifty-three to fifty-seven ounces of fluid; in well-authenticated cases it may contain much more than this. In a case reported by Traube (Collected Essaps, 1871, Vol. I., p. 988), the patient vomited four or five quarts of fluid at a time. This

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I am able to corroborate by three cases observed by me. In fact, the periodical vomiting of large and even of enormous masses of fluid is the most characteristic symptom. On the other hand, vomiting may not always be present, as stated by Dr. Wm. Pepper. I should consider this as an exceptional case; but should say that nausea, eructations and painful sensations are always to be found in such cases. The affection is of slow development, often requiring four or five years, and, as indicated before, mostly in consequence of chronic catarrhal gastritis, as indicated by the great variety of gastric symptoms; such as loss of appetite, thirst, eructations of liquid and of gas, pain around the waist and in the gastric region is apt to be severe; but none of these are as indicative of the nature of the case as the periodical vomiting which occurs whenever the relaxed and enfeebled stomach becomes overcharged to a degree that even its weakened muscular walls are excited to react upon their contents or, in fact, run over.

The ingesta accumulate in an undigested state, the digestive power being inhibited by unabsorbed peptones, as shown by the iodide-of-potash-test (Pepper, Vol. II., p. 727). We would hardly countenance the rude method of first introducing iodide-of-potash, and then of testing for iodine in the saliva every ten or fifteen minutes; nor could we approve of the method of distending the stomach by carbonic acid gas merely to outline the borders of the stomach. Much theoretical stress is laid by most authors upon physical examination of the abdomen, both by sight and by palpation. By oblique illumination a bulging of the left hypochondriacal region would indicate distension of the fundus of the stomach, especially by artificial distension. Under that severe expedient percussion would reveal the extent of the dilatation; but not only of the stomach, for the transverse colon would obscure the result. In case of distension by fluid, either intentional or natural, a splashing sound may be caused by manipulation, and this would also constitute a diagnostic sign. As this often occurs in perfectly healthy persons, I should consider it of little importance, but by abstaining from unnecessarily severe measures, I should prefer to judge the case more from its history than from very uncertain abdominal sounds.

Diagnosis is confessedly not always absolutely possible, as admitted by Pepper and other authors. They do not say why not, but I should suggest that this uncertainty exists only in rarer cases in the absence of periodical vomiting, and in the absence of firmness of the abdominal walls which do not yield the ordinary positive sounds of auscultation and of percussion. If, however, the lower border of the stomach can be made out the diagnosis should be in little doubt.

The prognosis, of course, depends entirely upon the cause and the stage of the dilatation. If cancerous disease is the cause of pyloric

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stenosis, the prognosis is very unfavorable, probably absolutely so. In advanced dilatation from any cause the outlook is usually unfavorable, though not always so, as certain methods of treatment have demonstrated. The patient wastes away under the absence of assimilating power when nutrition is so seriously interfered with; emaciation becoming extreme the patient finally perishes from inanition. Death may also result from perforation or final yielding of the extremely attenuated walls of the stomach; these may also be ruptured by injudicious use of hard tubes, or from sudden pressure from without.

THE TREATMENT. In the stages preceding developed dilatation our ordinary text-books naturally recommend strict attention to diet first of all. This should not consist of too much fluid and is to be administered in small quantities at a time. To write out a special dietary for dyspeptics requires an extensive treatise by itself. Among the remedies for gastric catarrh "tonics," leeches and Carlsbad waters were once the chief reliance.

As we are speaking now of falling of the stomach in consequence of enlargement, where pharmaco-therapeutics would not longer avail us, this is the place to mention the most practical and beneficial method of counteracting the progress of that condition. This is the method by means of lavage or washing out of the stomach, introduced by Kussmaul in 1867. In the beginning this was practiced by means of a stomach-pump with which that organ was first emptied of its contents, and then alternately filled and emptied of water (at blood-heat) usually of a mildly alkaline reaction. This rather cumbersome process was in due time superseded by the use of the soft, flexible syphon-tube with a funnel at one end. This is easily introduced in most cases. Warm water, pure or saline, is allowed to run in until it is seen at the mouth of the tube, when its mere depression will quickly empty the stomach. By repeating this process several times the dilated stomach is not only emptied of its contents but it is allowed to contract and to regain its tone if there is any contractility left. Even if there is no possibility of this, the relief to the patient is very appreciable.

The method may be practiced in cancerous as well as in non-cancerous cases. The latter condition naturally derives the greater benefit beyond mere temporary relief.

The introduction of the tube is not difficult in most cases; as any one will know who has ever introduced a probang. After two or three trials the patient will take the tube readily, and often learns to introduce it himself. Sword-swallowers are an example of the toleration of the esophagus. Still, there are cases where the irritability of the fauces is so great that it can be overcome only after many patient and tentative trials. In other cases the tube has to be abandoned altogether. It is

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advisable to introduce it every day for some days; later it may be used less often; but always at intervals during which the accumulation of fluids is to be prevented. An hour before a meal is the best time to prepare the stomach for the reception of food. In times past liquid food was thought to be best in such cases; but since it was learned in more recent times that liquids are not absorbed by the stomach, it was found better to administer more substantial food in small quantities.

This sketchy description, like much more elaborate treatises which have been consulted, serve only to impress upon the mind the sad fact that we have been dealing with the *end and outcome* of a long and painful pathological process, in the discussion of which we might be in danger of losing sight of, and of utterly neglecting to trace, this monstrous state from its beginning.

The tendency to accredit those abnormities of the stomach to mechanical causes has already been pointed out while speaking of gastroptosis. It is true that falling of the stomach may and does occur in various conditions, some of which may be mechanical, such as tumors, lacing, etc.; but by far the greater proportion are the result of pathological changes of the most delicate nature occurring in the histological elements of the stomach, now mostly accessible to the microscope, of whose powers we should early form a proper conception through the examination of slides, and even through the means of excellent drawings unaccessible to the student of fifty years ago. Of these finer changes the beginnings are unfortunately apt to escape the attention of patient as well as of physician, who then sums up the end-results under the head of gastroptosis and gastrectasis, the latter due mostly to narrowing of the pylorus, while those not infrequent forms of gastric dilatation from gradual weakening of the substance of the stomach receive but scanty attention.

If we intend to practice preventive medicine, our most earnest thought should be directed to the known changes in the substance of the stomach, and our imagination allowed to unravel the remoter conditions of disease. It is probable that we, as physicians, do not allow the imagination sufficient play in picturing before the mind the minuter pathological changes occurring in the stroma of any organ, in our case, in that of the stomach. This is too apt to be considered, especially by the older school, as an inert bag for the reception of victuals, or to be blown up with gas for diagnostic purposes; also, to bear the strain of excessive medication.

Instead of all this, the physician consulted about apparently the simplest case of dyspepsia, will do well to call up in his mind the most intricate structures of the digestive organs: its serous covering; its muscular layer; its mucous membrane. To stop there he would find

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himself only at the nearest outposts; and the mind would proceed further to recall the finer structure of the peritoneal coat with its endothelium, its stroma or basic layer, its lymphaties, its bloodvessels, its capillaries to where they merge into the stroma, and, what is of transcendent importance, he would regard with redoubled interest the nerves and nerve-ganglia entering into the structure (Strickler, Vol. II., p. 618). This is not a quotation from Strickler's work, but he is quoted as an authority for the existence of nerves in those membranes. Beneath this, we recall the muscular coat, with its layers of unstriped (organic) muscular fibres, also with numerous nerve ganglia; these are also numerous in the submucous tissue which lies next to the muscular coat.

In the consideration of the mucous layer, that much enduring portion and most intricate of all, the nerve elements necessarily play the most important part. Hence, our imagination will endeavor to picture them and their influence to the mind. Only the most skilful and special research reveals them; but they are there, though they escape recognition in ordinary autopsies where we see only the coarser changes and appearances while the finer and essential ones go unnoticed.

We can easily recall to mind, and have it constantly before us, that the functions of all these intricate membranes—nervous, muscular and mucous—could not exist or be functions at all without the nerve-elements permeating them. It is to these that the life-function of the organs is due, as well as their development and daily regeneration.

An organic, living being is essentially a nervous system to which all other tissues and organs with their functions are subordinate.

When, therefore, a set of symptoms indicating a pathological process, appear, it is reasonable to assume that the nerve-elements of the organ are involved. This may be primary involvement or it may be secondary. As a rule, even eminent pathologists like Virchow, do not permit their mental vision to penetrate as deeply as they might into pathological tissue-changes in order to recognize their incipient stage, not to say the cause, notwithstanding the enormous stride made by cellular pathology. Thus, while speaking of myomata, or muscular hypertrophies (Morbid Tumors; 1867, Vol. III., Part I., pp. 97 and 123), Virchow says that their causes are generally easily recognized; they are dependent on "local irritation" which from exterior parts reaches the muscular coats. Usually the disturbance begins in the mucosa * * * especially in the form of chronic catarrh of the stomach, in myomata of that organ. Referring to myxomatous swelling (degeneration) Virchow points out its process by designating mucous tissue as "unripe fatty tissue;" for, indeed, in the majority of cases it will become changed into fat-tissue, its cells simply taking up fat. It is in observations and generalizations like these that Virchow is great.

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Analogous information may also be obtained from his "Cellular Pathology," Chap. VII., on mixed active and passive processes.

This leads us to picture before the mind some of the ways in which changes occur. But when we allow our mental vision to penetrate further, we are able to discern something that lies deeper as a cause of degeneration than mere local irritation, poisons, injurious food or overeating. These are only the coarser *exciting* causes; they would be harmless without *predisposition* of the tissues of the stomach or of any other organ to degenerate. Myomata, says Virchow, are not congenital or even noticed in youth. Neither, according to my personal experience, is falling of the stomach from over-distension or other causes. But predisposition is there long before such changes are seen. Whether inherited or acquired, predisposition does not manifest itself until later in life, as, for example, in tuberculosis, various neuroses, mental diseases—all very rare in youth and childhood.

Hence, this degenerative process ending in hypertrophy or atrophy of the stomach, with thinning of its walls, its reduction to a flaccid sack lying low in the abdomen, the participation of the duodenum, which, in two of my cases formed a continuous pouch with the stomach, with their almost transparent walls—is to be sought for and found in the progressive destruction of its nerve-elements, or else it would not be the helpless inert mass which we find it to be in autopsies.

The degenerative process may be primary in any tissue-element entering into the composition of the serous, muscular or mucous membrane; but we are forced to assume that it often, if not always, does originate in the nerve-elements of the stomach.

The reasons for such a conclusion are to be found in the long train of dyspeptic symptoms preceding gastroptosis or gastrectasis. The subject of nervous dyspepsia comes very close to the every-day experience of the physician; its subjects are treated with care but often with the mental reservation that their disease is rather of the mind than of the body, and that hence, their disorder is imaginary.

The patient's diagnosis of his own case is most always sure to be wrong, but the physician should not err in declaring that there is nothing the matter. There always is something wrong when the patient refers all his bad feelings to his epigastric region; when he has little appetite; when food distresses him; or when he imagines that certain bland foods are hurtful; when he feels distress, pain or ache, or abnormal sensations of some kind; when he either imagines or when he actually is troubled with gas which oppresses him; if, in addition, he has nausea at times, then the case is plain enough. If, on the other hand, he eats and has normal fecal evacuations, notwithstanding many distressing symptoms, then dyspepsia—if this means indigestion—is not there. But without

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unduly lengthening this article, it deserves to be briefly emphasized at this point that all the various subjective and objective symptoms of such a case are due to *nerve-affection*. This may be primary or it may be secondary, the morbid process starting in non-nervous elements, having extended to the scattered nerve-ganglia; but neurotic it is, in all its essential features. At first it is only functional; but there is in all such processes a time beyond which a functional disturbance becomes degenerate, and the tissues generally assume the inert, flaccid and often the enormously distended condition which is to be attributed to the paralytic degeneration of the ganglia supplying it.

It is never an agreeable occupation to write about incurable diseases when we would so much prefer to record success. But the feature which this record most desires to emphasize is that we are *not dealing with an incurable disease, but with the incurable terminal stage of a disease.* This is also the case in other pathological conditions. What we call consumption of the lungs, is already far beyond the curable stage when the physician sees it. The same applies to cancer; also to chronic forms of nephritis as well as to cirrhosis of the liver. What we call slight symptoms, barely noticeable by means of physical examination, are, in fact, indications of far-advanced disease.

If, in a case of dyspepsia, there is already serous vomiting in large quantities, and when this occurs periodically, degenerative disease of the stomach is already far advanced, though perhaps not beyond relief, if not recovery. It is in the curable stage in which the physician can only hope for success, and this curable stage is to be found in patients with apparently trivial ailments.

It is therefore desirable that all cases of dyspepsia in their beginnings should be regarded seriously by the physician, and his attention given regardless of the circumstance that there is no actual dyspepsia present. I mean to say that actual dyspepsia, that is, indigestion arising from an actual pathological state known as catarrh of the mucous membrane of the stomach, is the form that deserves that name; but is by no means the most intractable condition. That form, on the other hand, called nervous dyspepsia, is really much more insidious and formidable. Such cases are characterized by the ability of the patient to perfectly digest his food, as indicated by normal fecal evacuations. These may be sluggish, and they may occur even at intervals of several days; there may be appetite, but food causes discomfort, yet, as the result shows, it is digested until more pronounced neurotic changes occur.

Those causes of nervous dyspepsia, therefore, constitute the beginning of the more serious degeneration of the gastric layers in which therapeutic measures are still applicable and successful in by far the majority of cases. Acute and chronic gastric catarrh, together with

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nervous dyspepsia, are subjects which, with their therapeutics, do not happen to come within the scope of the subject treated of here. But it is particularly to the neurotic source of gastrectasis that treatment by homœo-therapeutics deserves our earnest attention. And in this regard we are called upon to consider especially those remedial agencies which promise to be most effectual in nervous diseases; this applies to those therapeutic agencies whose toxic effects (the word "physiological" in this sense is a misnomer) point to their especial relationship to the nervous system. In many remedies the relationship to the mucous membrane and to the nervous system are combined, and these constitute a most important group. Among them may be named chiefly Phosphorus, Arsenic, Cuprum, Argentum. Among those derived from the vegetable kingdom Nux vomica stands at the head of those having a relationship to the nervous system; while Ignatia, Cicuta vir., Conium mac., and Actea rac. present many points of that kind, as indicated in those cases which have reached, or may not reach, the neurotic stage, with its degeneration of nerve elements.

The class of remedies to be considered in the catarrhal forms not yet approaching the degenerative stage, is very large, and together with the all-important subject of diet cannot now be considered as a part of this subject without exceeding my limits of time and space much farther than it has already been done.

It is possible that surgery may yet come to the rescue in extreme cases of this kind, when the stomach has become atrophied and distended beyond recovery, and is found out of place low in the abdomen. In such instances its removal might result in recovery provided that the duodenum and other portions of the intestinal canal are still in a healthy state. Final judgment must be left to surgeons of experience.

Though I am unaware of any notable achievements of various forms of electricity in neurotic conditions, the application of static electricity is worthy of a trial in gastric dilatation.

OBSERVED CASES AND THEIR RESULTS.

CASE I. 1867-8. Mrs. ——, aet 45; has a history of lingering illness of more than a year, with dyspeptic symptoms of a severe nature. At the time of the first visit she had much epigastric pain and periodical vomiting, at first not in large quantities, but which lately had increased exceedingly, filling one-third of a washbowl with blueish, and more frequently with greenish watery fluid with white flakes of undigested food. Emaciation was great, and this, with the inability to retain food, produced extreme weakness. There were present, as in another case, nausea and thirst; the general condition permitting only a very unfavorable prognosis.

At that time the use of the stomach-pump, as introduced by Kuss-

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maul in that year, was scarcely known, and if so, its attempted application in so hopeless and sad a case, would not only have been useless and distressing, but dangerous, as the soft tube was then unknown. The patient died after a protracted illness; the end was lingering and painful.

AUTOPSY: The stomach was considerably but not inordinately distended; its walls were pale, thin and almost transparent. An unusual and remarkable appearance was presented by the pyloric portion; this was enlarged, and, with the stomach, formed a continuous cavity with the duodenum. Opening it up revealed an ulcerative condition of the pylorus whose circular fibres had become loosened, so that two fingers could easily be passed from stomach to duodenum. Its wall was extremely thin and blueish, so that its fluid contents could be seen moving inside.

CASE 2, 1868, Feb. 21, Mrs. G. S. Seen in consultation out of town. Aet. 60. Began vomiting Aug. 6th, but was not well for three years before. Now vomits once in two days at the rate of two quarts at a time, in the patient's own words "pouring out as from a hydrant." At first there was much hard pain across the bowels; now relieved whenever she vomits. Thirst excessive; she says that she "could drink the ocean dry." At the time of visit she had no pain, but a sense of fulness across the waist and a crowding sensation. The vomiting occurs without nausea; stools small, hard and dry. Examination by palpation only showed the abdomen to be large, soft, with indistinct dullness and tympanitic resonance here and there. Pulse 100, Temp. 97; failing strength.

The stomach-tube was considered, but, I believe, not made use of, as the patient died a few days after my visit.

An autopsy was made at which I was not present; but it is reported —if I am right—in the *New England Medical Gazette* of March or April of 1886. The number is not at hand; but I remember the report to have stated that the stomach and duodenum were diseased and much enlarged; a condition also found in the case previously reported.

CASE 3. 1895, Nov. 22d, Mr. F. S. L. at the Massachusetts Homœopathic Hospital, during my term of service. Patient, a machinist; aet 39; his illness dates back seventeen months; began with dull pain around the chest; gastric hemorrhage of a cup of liquid blood; now pallor, emaciation and periodical sharp pain about once a week, beneath the ribs and extending to the stomach and bowels. He had to take morphine before coming here. Has abnormal appetite; the more he eats the more he wants. Much thirst; bowels sluggish. Examination of blood shows diminution of red, and increase of white corpuscles. Periodical vomiting of nearly a chamberpot full, repeated at intervals of two or three days. Has nausea and sour eructations. The vomited masses are bluish, and mixed with milk and milk-toast; also some slight

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bile-discoloration. Physical examination disclosed nothing positive. After using a few remedies, such as *china, ferrum oxid.* and *ipecac* 3x, without effect, I introduced the flexible stomach-tube. This, partly by itself, and partly by inducing vomiting, brought up a large quantity of serous liquid, mucus and flakey material. The stomach was then washed out by alternately filling it with warm water, and emptying it several times. This process was repeated every day about two hours before his noon meal, in order to prevent the stomach from becoming distended. There was no more vomiting after this; in three or four days the patient introduced the tube himself, and by taking only small quantities of food (omelette, milk-toast, small quantities of fine-cut meat) he improved in health, and asked to be discharged, anxious to use his stomach-tube himself, as it had greatly benefited him.

We heard from him later that he was better, and that he was able to work again. It is not to be presumed that such cases can recover entirely.

To illustrate the difficulty of using the tube, there was at the hospital at the same time with the above case, an elderly woman suffering from chronic gastric catarrh, the prominent feature of which was nausea and frequent vomiting of large quantities of clear and very viscid mucus—an old intractable case. The stomach-tube was suggested and tried in opposition to much resistance and excessive irritability of the fauces, on account of which the tube had to be given up notwithstanding many patient attempts.

Case 4, Mrs. A.—First consulted in this case in May, 1897; aet. 86; this, though not one of gastroptosis, was nevertheless one of chronic catarrh with decided hypertrophy of the walls of the stomach causing only a moderate degree of enlargement eccentrically, as well as a diminution of the cavity of the stomach; which, though much thickened and heavy, did not descend into the hypogastrium; indicating that mere weight is not sufficient to cause ptosis.

The case was one in which the patient, suffering from senile nervous insomnia, had for nearly two years resorted to sulphonal in five-grain doses, if not every night, at least several times a week. Slight dyspeptic symptoms appeared soon after beginning the use of this drug. These symptoms increased in the course of several months in the form of vomiting up every meal, preceded by nausea which was always allayed by taking a small quantity of food. This was the characteristic feature for more than a year. It seems that this case should have yielded to careful diet and certain remedies, among which phosphorus was best indicated, as was also argentum nitricum. Perhaps these would have proved curative had the patient been persuaded to omit sulphonal.

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This may or may not have been the exciting cause of the disease; at all events the patient died, although at the advanged age of 87.

The autopsy on the day of her death revealed an hypertrophy of the muscular coat and great excess of cellular tissue, causing the walls of the stomach to be one-half to two-thirds of an inch in thickness; especially at the cardiac orifice; ulceration appeared in spots, some large and gangrenous. The pylorus presented a similar appearance, being at the same time contracted. In this case the hypertrophy was not distinctly discernible before death; but would undoubtedly have ended in atrophic distention of the stomach had the patient lived long enough to allow that degree of distension by degeneration to take place.

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SOME OBSERVATIONS UPON HYPERCHLORHYDRIA

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Hyperchlorhydria, a rather common condition, sometimes overlooked, frequently disregarded; yet it should not be so, for it is usually a signal, warning the alert and far-sighted physician of more serious mischief yet to appear, if not already present. We prefer to regard hyperchlorhydria as a warning signal, of varied import; rather than an affection of the stomach requiring specific medication.

Indeed, many cases of this secretory neurosis, in which there are no recognizable signs of disease to be found in the stomach, aside from the hyperacidity, will not prove amenable to the resources of our medicinal therapeutics; will not be permanently influenced by alkalies; will not be more than ameliorated by such remedies as atropine; will not even be cured by the accurately selected *similimum.*

We suspect the existence of hyperchlorhydria generally from the gradual development of a train of symptoms which, upon their first appearance, may be slight in degree; but which will surely increase in their intensity, and become more frequent in their recurrence. We confirm our suspicions by the modern methods of gastric diagnosis. The earliest symptoms, in our experience, is pain, or, at least, discomfort, referred to some part of the epigastrium, and experienced some hours after the ingestion of a meal. This is commonly regarded as a symptom of dyspepsia. It does not yield permanently to those remedies commonly useful in dyspeptic cases. It may be quickly ameliorated, for the time being, by more food; especially if the latter be meat or milk, or by a soda-mint tablet. Patients are quick to make these observations, and they eat frequently and have generally restricted their dietaries somewhat, before consulting a physician.

Soon, gnawing, a sensation of burning and pressure, are added to its symptomotology. Occasionally, nausea or vomiting may occur. During the existence of the pain, the epigastric region is tender; but, the soreness or tenderness is not localized. We do not find the exquisite point-tenderness supposedly characteristic of gastric ulcer. The presence of a point of special tenderness in the epigastric region, or to either side of that region, calls for especial care in differential diagnosis. The support or gentle pressure of the hand, is often agreeable during the attacks. Bodily exertion or exercise, on the other hand, are generally

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avoided; they seem to augment the suffering. The rapid transition from a state of suffering and distress to one of comparative well-being and comfort, when albuminous food or meat is taken, is often remarkable. The patient, at times, finds himself at a loss for words that will accurately express the weak, gnawing distress which he experiences two or three hours after a meal. "Pain" does not always exactly define his feelings at such times. Exceptionally, this distress does not recur after every meal, but only at certain periods of the twenty-four hours.

We cannot agree with the general statement that loss of flesh does not occur. Not infrequently, in spite of many meals a day, of a highly nutritious character, emaciation and loss of strength are quite noticeable. At least, such has been our observation made several times. "The more he eats, the thinner he becomes," has expressed it in not a few instances. Food is taken rather to assuage the gastric distress, and food so taken does not perfectly nourish the body. Vomiting has been exceptional, more often nausea is succeeded by an acid eructation, or the regurgitation of a mouthful of fluid followed by vertigo, faintness and a desire to lie down.

Constipation may be a troublesome feature, but is not universally present. Lowness of the spirits, melancholy, a hypochondriacal frame of mind, are usual accompaniments. The mental anxiety may take the form of a fixed apprehension that serious organic disease of the stomach already exists. The more intelligent the patient, the more scientifically will he elucidate his apprehensions for the benefit of his physician. The periodical return of the gastric pain and distress, at a certain time after each meal, is often noteworthy. One of my own patients declared that it recurred two hours to the minute, after food had been taken, whether he was asleep or awake.

In the absence of food, copious draughts of water, the swallowing of a considerable amount of saliva, the secretion of which has been provoked by the chewing of spruce gum, will ameliorate the pain. The slow mastication of a bolus of whole-wheat grains, swallowing the saliva produced, is often quickly effective; and, in some of our cases, has seemed preferable to the immediate taking of more food. Too frequent meals may have a tendency to add other discomforts, although there has seemed to be an almost unlimited capacity to digest in these cases, provided the food chosen was not too starchy in its composition. With such a train of symptoms as our guide, we test for the HCl. in the usual manner. Two or three drops of the dimethyl-amido-azo-benzol solution are added to ten cc. of the filtered gastric contents, removed an hour after a morning meal; consisting of a baker's roll and ten ounces of water or unsweetened tea. Then a deci-normal soda solution is allowed to flow, drop by drop, into this from a burette, until a pure yellow color

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has replaced the red. The number of cc. of this solution which would neutralize *100 cc.* of such a stomach's contents, multiplied by 0.00365, will give us the percentage of HCl. present. Then we may, in addition, ascertain the total acidity of our specimen. A total acidity ranging between 70 and 90, or even higher, considering the normal to be somewhat between 40 and 60, will confirm our diagnosis.

A neurasthenic breakdown is not infrequently, we believe, foreshadowed by the symptoms of a hyperchlorhydria; and their significance in this direction should never be disregarded by the general practitioner under whose observation these cases will likely first come. We have seen cases, a number of them, in which the first pronounced symptoms indicating that the wear and tear of overwork and worry were tending towards a nervous break, have been the gastric symptoms of a hyperchlorhydria. It is almost useless to attempt to correct these cases by internal medication. The therapeutic indications are for a radical change in the life of the individual. If he has been too studious, he must rest his mind and exercise his muscles. If dissipated, he must be in bed at ten, and give up his stimulants. The hyperchlorhydria in such cases yields quickest and most permanently, in our experience, to a rest in the woods. The patient should take to the woods, where Nature is in her peaceful moods. Rowing is the best of physical exercises, so a convenient lake is a desirable adjunct. With his days spent in tramping and rowing, long nights in bed, sound sleep, and the diet of such cases need not be too scrupulously watched. Such a plan of treatment cures the hyperchlorhydria of brain-workers, threatened with neurasthenia or suffering from it, better than any drug. Alcoholic stimulants, especially beer and whisky, are distinctly disadvantageous. Whisky sometimes produces a momentary amelioration of pain that is a delusion and a snare to the unwary.

Not a few cases of gastric ulcer are heralded, in their incipiency, by symptoms of hyperchlorhydria. The patient has grown anemic; or, if a female, has shown signs of chlorosis, and has had disturbances of the menstrual flow. He or she begins to suffer pain, not immediately after a meal, but at a later period of digestion. Tests reveal increased acidity. Now, if the mode of life of such cases can be rearranged, homœopathically indicated remedies cure in this stage. If this stage is neglected by the patient, his or her future will probably be gastric erosion or recurring ulceration.

I have now under observation a man who has suffered from greatly dilated stomach for some two years. Hyperchlorhydria and its train of symptoms was indeed the first complaint. It was an occasional condition in the beginning, but gradually become almost constant. His pains, which are severe, his acid vomiting are caused by the increased

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secretion of very acid gastric juice; at least it seems so. There has been nothing so effective in this case as lavage. After three or four washings the acidity diminishes and a period of comfort follows. I explain the hyperacid secretion, in this case, by supposing that the lack of motor power permits food to be retained for a long time, and that the latter causes, by irritation, increased secretion of gastric juice. While opposed to the cultivation of "the stomach-tube habit," we are decidedly in favor of stomach-washing, in selected cases, of hyperchlorhydria. At times it seems to provoke a reaction to internal remedies, in cases that had hitherto been very obstinate. This is especially true of those cases in which hyperchlorhydria is associated with chronic gastritis, with dilatation or with motor insufficiency.

Paxson has laid great stress upon the pernicious effect of an overindulgence in tobacco in these cases. He finds it easier to cure if the habits of smoking and chewing are entirely given up. Coffee is harmful to some cases, in our experience, and its effects must be carefully estimated in all cases; preparatory to treatment. In those cases in which a radical change is impossible, we have obtained good results from cold sponge-baths daily, followed by systematic exercises. The avoidance of "worry" is an essential in the management of all cases, especially those associated with neurasthenia or a neurasthenic tendency. Fletcher's little book upon "Menticulture" is sometimes a capital prescription. We have seen a few cases that were markedly aggravated when the hot season was well on, inquiry revealed that such cases indulged, to excess, in cold, acidulated drinks, such as iced tea flavored with lemon-juice. Hence we have thought it advisable to prohibit acidulated beverages. Highly seasoned foods generally aggravate or perpetuate a hyperchlorhydria.

It is well established nowadays that hyperchlorhydria may be an associated condition in many diseases of the stomach, as well as in other affections quite independent of that viscus. The necessity for a careful differential diagnosis in all cases presenting this symptom, becomes at once apparent. Bickley has called our attention to the clinical importance of the estimation of the quantity of HCl. as a routine measure, in all diseases of the stomach; previous to beginning their treatment. It is not my privilege to consider the therapeutics of this subject at this time, but Dr. Halbert will easily show that the therapeutic portion of the subject is by far the most interesting, and far better understood.

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THE TREATMENT OF HYPERCHLORHYDRIA

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It is only of recent date that the term hyperchlorhydria has applied to more than a hypersecretion of acid in the gastric contents. That the functional disturbance caused by hyperacidity generally leads to more complicated conditions and very frequently is the fundamental factor in organic diseases of the stomach, cannot be denied. Again, it may be stated with emphasis that a great share of the diseases which affect the stomach are either typical cases of hyperchlorhydria, or the initial cause starts with this condition. It will, therefore, be evident that in our treatment we should not overlook this fact, else our remedy does not apply to the symptoms in proper sequence. We must, however, admit that, as temperaments differ, so we may find a wide variance in the habits of digestion in different people.

To one person a hyperacidity of the stomach may be an idiosyncrasy, just as a deficiency in that respect is natural to others. While such conditions are abnormal, they do not establish a disease until other symptoms appear which pervert the physiological principle of digestion. Thus, hyperchlorhydria is a hypersecretion of acid *plus* other conditions and symptoms. The other conditions are (1) the atonicity of the mucous glands, mucous membrane and peptic glands of the stomach, due either to the debility of the digestive function from the lack of sufficient proteids, or from the long-continued acid irritation; (2) the tendency to general ulceration of the gastric mucous membrane; (3) the increase of ferments and the quantity of gastric juice; (4) a flabby condition of the muscular structure and a debilitated stomach peristalsis; (5) a tendency to rapid digestion and a consequent gastralgia.

It is of the greatest importance that we regard, first of all, the nervous system in this class of patients. Doubtless, in many cases, a neurosis is the pathological disturbance. Therefore, take the overworked away from the strain of business; send the socially inclined out of reach of society demands; stimulate the peripheal circulation by the cold sponge-bath, massage and sufficient exercise. Thus to give tone to the nervous system enables the digestive processes to perform a more natural function. Encourage also the regular meals, with sufficient time for each. The hyperchlorhydria patients should be well fed; three meals are not always enough, a fourth may be sandwiched in to advantage. We must remember that rapid digestion is one of the features

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of hyperacidity; therefore, the stomach is inclined to be empty for too long a time between meals. If an excess of acid remains too long in the stomach, gastric ulceration is liable to occur. Remedies which relate to nervous exhaustion and perversions are well known, but we too frequently forget to prescribe these for a stomach-disorder when nerve irritation is the cause. Phosphoric acid is recognized for its correction of neurasthenic debility; picric acid, the zincs, phosphorus, ignatia, anacardium, pulsatilla, kali phos. and natrum phos. should always be remembered when a protoplasmic loss contributes to the digestive irregularities, which always attend a well-defined case of neurasthenia. Cannabis indica, passiflora, coffea, avena sativa, and similar remedies should not be overlooked when insomnia and mental irritability complicate the case, and so we might call to mind many useful medicaments, which, applying first to the neurasthenia, pertain most decidedly to the secondary condition of hyperchlorhydria. When the nerve control of involuntary fibres is depreciated, we can easily understand a gastric or intestinal debility, and with this knowledge always in mind, we are to look for the real cause of hyperchlorhydria, which must first be removed.

The diet is the most important part of the treatment. It should consist mostly of the albuminoid forms of food; meat, eggs, fish, oysters and milk should be given in abundance, even though at first they may cause vomiting. In this way the acid is utilized and rendered inert so far as starches are concerned. If a sufficient amount of albuminoid food is given, starches may be eaten in moderate quantities. I have always found a mixed diet to work nicely, provided, enough meat is used; this, however, must be prepared in a manner not to tax the mechanical features of digestion. Between the meals I frequently give milk, or a raw egg in milk. The secret of the treatment consists in keeping the stomach moderately full most of the time. The constant belching and distress, from bowel and stomach gases, disturb the patient, because the starches are not digested in an extreme acid reaction, and the alkilinity of the upper intestine is generally disturbed by the hyperacidity of the stomach contents. It is too frequently the habit to exclude starches. That article of food, however, is a necessity in such cases, and if enough albuminoid foods are used to neutralize the gastric acids, there will be no trouble in digesting the vegetables. It is not, however, best to let the starchy foods exceed the albuminous. With a mixed diet it is always well to consider the use of a diastase.

Alcohol and condiments must be forbidden, but water, in considerable quantity, should be taken before each meal. In extreme cases, hot water, with a little bicarbonate-of-soda will give great relief, and, at the same time, it will temporarily overcome the acidity and correct the too rapid digestion. Alkaline waters almost always give good results.

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Lavage should not be overlooked; it is indicated generally when some catarrhal gastritis is associated with the hyperchlorhydria. It should be employed at least once a day, and best before the midday meal, and always on an empty stomach. It will not only dilute the acid, but it cleans and stimulates the gastric mucous membrane preparatory to digestion. The contra-indication of lavage is gastric pain, particularly after this measure has been employed for some time. I invariably use the recurrent tube, forcing the air into the glass containing the water, by means of compressed air. The double tube is not only smaller, and, therefore, easier to introduce, but it obviates the necessity at times of to much gymnastic effort on the part of the patient to get the water out.

The medication, of course, depends upon the case and the symptoms expressed. Bicarbonate of soda is the best and safest alkali and may be given at any time, though I prefer it in hot water before meals. Peppermint with soda is often a good combination. Calcined magnesia is better than anything; it may be given in heroic doses; also, to neutralize the acid, rhubarb in combination with soda and magnesia is valuable when severe constipation exists.

The internal remedies may be enumerated in about the following order:

MAGNESIA PHOS. I would think of this first, from the physiological conditions. It overcomes the gaseous eructations, the burning pain in the stomach, the abdominal distention, and cares for the constipation to a considerable extent.

ROBINIA. From a symptom standpoint this should be thought of above all other remedies. That it is homœopathic to hyperchlorhydria I have not the slightest doubt. Its physiological action, through the pneumogastric nerve, has a tendency to arrest digestion by the creation of an excessive acidity. When it is called for, in a potency, we find the following symptoms prominent: A low-spirited mental state; constant eructations of a very sour fluid; often vomiting of an intensely sour liquid; sharp burning pain in the gastric region, worse when the stomach is empty, and always relieved by taking food. I have generally used it in the third potency, repeating the dose at frequent intervals. It is a remedy which should be given for a long time to get any satisfactory results.

CHINA ARSENICUM. This is a favorite remedy of mine in many stomach diseases. It is useful in this disease when there seems to be an alternation of hyperacidity and a decrease of acid. Such a condition is quite common in cases of hyperchlorhydria; that is to say, there will be days in which acid secretion will be below the normal, and gastric mucous membrane seems to be in a state of atonicity. Then the tonic effect of china and arsenic is valuable; the thirst for water is pro-

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nounced, yet it disturbs; the same is true of food, for, while it is desired the stomach seems to object to it. These conditions are generally transient, and yield nicely to china arsenicum.

ARGENTUM NIT. This is one of the most useful remedies we have for the later stages of this disease. When the rapid digestion ceases and the peristaltic power of the stomach is lost, then *argentum nit.* is the remedy called for. In this state food remains too long in the stomach as the result of gastric dilatation; gases are excessive, and are ejected from the stomach with force; the great desire for food is displaced by an apathy for the same, because it is not digested, though the amount of acid is not necessarily decreased. When *argentum nit.* is indicated the stomach is really in a neurasthenic state, and the patient is in every sense a "nervous dyspeptic." Painful sensations in the region of the stomach are common, and there are signs of much weakness. This remedy should be made fresh, in an aqueous solution.

HYDRASTIS. This should also be considered when the hyperchlorhydria is associated with an atonic dyspepsia; it is particularly useful in old people; when chronic gastric catarrh precedes the hyperchlorhydria and the sub-mucous tissue has been involved for some time, there is no better agent.

NUX VOMICA, ipecac, iris, arsenicum, bryonia, sulphur, and many other common remedies for gastric perversions should not be overlooked. The totality of symptoms will, of course, govern their selection. My aim in this paper has been to suggest the remedies not so well known and which pertain more to the special pathological conditions.

GRINDELIA ROBUSTA is rarely used, and more rarely thought of, in diseases of the stomach, yet in many obstinate cases its action is remarkable. Physiologically, it produces a paresis of the pneumogastric, interfering with respiration, and, hence, is often indicated in asthmatic conditions. As the pneumogastric supplies fibers to the solar plexus for inhibitory control of the vasomotor action of the sympathetic, it is easily seen that it may be frequently called for when the gastric circulation is not properly regulated. That is to say, it is indicated when hypermia of the gastric membrane is persistent. Such a condition is bound to create hyperacidity. Therefore, symptoms attended by asthmatic and other neurotic characteristics will be greatly relieved by this remedy. I have employed it in many cases of hyperchlorhydria, when these features were paramount, and the results have been gratifying.

OREXINE TANNATE is a remedy of recent use which has given me many good results in old and obstinate cases of hyperchlorhydria, or, rather, in gastric perversions which follow hyperchlorhydria. By the old school it is used in two or three-grain doses before meals, when atony of the mucous membrane exists as a result of hyperacidity. It

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is considered as a stomachic, or, in other words, as a tonic for the debilitated gastric function. For that reason it has been successfully used in cases of primary anorexia, or in gastric conditions incident to anemia or chlorosis, and in neurasthenic or hysterical neuroses when the stomach is greatly disturbed and the simplest food is intolerable. In my experience, however, it is most frequently indicated at the termination of a hyperchlorhydria, when acid deficiency frequently ensues. Under such conditions, as digestion is supplanted by a tardy gastric emulsion, undigested food irritates the stomach and both a muscular and mucous atonicity appear. In just such conditions as this, which often baffle the physician, the use of *orexine* is of great value. I have used it most successfully in the first and second decimal triturations, and have not experienced any unfavorable reactions, even when given as often as every hour for several doses.

Before I leave this subject I should like again to emphasize the necessity of dietetic consideration in the treatment of all cases of this disease. The average tendency in all diseases of the stomach is to limit the diet. While this is correct in acute and chronic gastritis, ulceration, and many other diseases, it is certainly not the correct treatment in cases of this kind. I may add that I still believe the stomach was made for the digestion of food, and to deny it that function is very often a mistake, and prolongs gastric perversions. For that reason I oppose the average dietetic routine which is employed in many sanitariums and hospitals. We must remember that we have the exhaustion and debility of our patients to guard; we must furnish the fire which makes the steam. Starvation weakens and irritates the delicate nervous system, and, more than all, it discourages and renders inert the natural gastric habit. Show me a chronic dyspeptic, and I will point to a man who is afraid to eat and drink, who is a pessimist in all things, and whose neurotic shadow will not present the faintest outline of physical or mental stability. Food, both meat and vegetable, thoroughly cooked, properly served and regularly and carefully eaten, is a better medicine than any drug. It is certainly indicated, first and foremost, in the disease under consideration.

DISCUSSION:

T. E. COSTAIN, M. D.: I wish to emphasize the point made about feeding patients that have been heretofore starved. It is, I think, worthy of careful consideration. So many sanitariums, and particularly places where they diet patients unduly, weaken the patients so frequently that even when put on a full diet it takes a long time to bring back their strength. I have in mind a case that was at the Battle Creek Sanitarium for eight months in 1899, a man who had this condition and had for several years. At the end of eight months he came

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out much emaciated, having suffered great loss of flesh and general tone. He came under my care at this time and I put him on a vigorous diet, commencing rather carefully at first; he began to build up almost immediately. I saw him the other day and he now weighs two hundred and ten pounds; he was then weighing one hundred and two pounds, when I first saw him. He has had no trouble since he began to eat as I had directed him. Many cases of this character are "dieted" too much. This particular point I desire to call your attention to, as it is so often overlooked.

C. B. Gilbert, M. D.: One of the worst classes of patients in these stomach conditions are the people who are always thinking about their stomachs and are afraid to eat. They try to find some reason why they should not eat anything and everything. They give more trouble than any other class. If they have something to keep their minds occupied, so that they do not think about their stomachs, but sit down and eat each meal and go to bed early, they do better than by going to a sanitarium and being dieted.

In the method of treatment I could not follow the Doctor, especially where he bases his prescriptions on pathological hypotheses, but the statement that the remedy should be selected according to the totality I most heartily agree with. I think it is not wise to try to palliate these acute or even chronic conditions with temporary expedients, but to pay attention to the diet, and especially to the mental life of the patient. It is a pretty hard thing to straighten out a stomach which has gone astray under a terrible mental strain which is still continuing, and all you can do is to put a pair of crutches under that patient and keep him going until things change; when the strain is off the stomach will right itself, provided the leading cause is not organic, or, as Hahnemann says, the dynamis has not been disturbed. They are hard cases to treat sometimes, but still if we differentiate carefully we get rid not only of the hyperacidity, but also of the causes.

H. V. Halbert, M. D.: In reply to the doctor I would say that I do not apply my treatment entirely in accordance with pathological suggestions. In criticism of your statement, I would suggest that instead of putting crutches under the patient, we should put food into the stomach. I have received many cases from the sanitarium under discussion. While I believe they do some good work, I am confident that their uniform method of diet is not correct. A case of chronic gastritis, acute gastritis, hyperchlorhydria, or ulcer of the stomach is given the same diet. This is a too frequent error in the dietary of other sanitariums. I have systematically and persistently forced the feeding in hyperchlorhydria as well as I could, without irritating the stomach, and I believe it is the logical treatment and should be carried out, plus the remedies indicated medically.

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SPECIFIC TREATMENTS

WM. C. GOODNO, M. D.
PHILADELPHIA

When any medicine or method of treatment sufficiently often controls a combination of symptoms or a well defined form of disease, even if it is closely related homœopathically to the case, to demand its employment rather than the selection of a remedy strictly upon homœopathic indications, it becomes specific medication, or specific treatment. This, then, is the sense in which these terms are used upon this occasion.

At the outset I desire to state that the title of my paper was inspired by one prepared by that excellent clinician Dr. Andrew H. Smith, and which appeared in the *New York Medical Record* for March 15, of the current year. As all the treatments referred to in that article were medicinal, and addressed to the exciting causes of disease, it would have been entirely proper had the author entitled his paper "Etiologic Medication."

Limiting myself upon this occasion to the treatment of infectious diseases, I will recall that, if pathogenic organisms are introduced into a healthy body (and, in parenthesis, it may be said that while health is a relative term there are, practically, healthy people) a reaction against the intruders is at once developed. In the warfare which is waged between the phagocytic cells and the intruders the body suffers much irritation and develops many symptoms and, often, well-marked pathologic changes. All that goes wrong in such a body is the result of the injury done by the unwelcome visitors and the strain of the organism in overcoming them. If the development of the bacteria is inhibited and their poisonous products destroyed, health is rapidly restored. Some of these infectious diseases are due to perfectly identified organisms, and, for which, in a few instances, we have discovered specific treatments which when applied at the proper time, and in the proper manner, give highly successful results. The agents employed are of various sorts, or variously combined, so as to strike directly at the cause or causes of all of the numerous symptoms and their underlying pathology. They are not necessarily medicines. Whether it is best to employ such specific methods, or to antagonize the results of the influence of the poison upon the blood and tissues of the body by the devious paths of symptomatic prescribing, is one of the most important questions before the homœopathic profession to-day, and a question to which the speaker hopes this paper may call increased attention.

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Of the specific methods of treating infectious disease serum-therapy is best known and has thus far given the most perfect results, although the success achieved by the *carbonate-of-creasote* and the *salicylate-of-sodium* treatments of pneumonia have thus far been highly satisfactory. The mortality from pneumonia in hospitals, and hospital reports are in general much more reliable, varies from twenty to thirty per cent. Perhaps twenty-five per cent represents a reliable average. This probably holds good for the homœopathic as well as the old-school hospitals. Mortality is rarely as low as fifteen per cent in private practice. It would be impracticable for me within the limits of a paper one is permitted to read before this body to bring together the statistics and arguments in favor of this treatment. I can only state that the mortality estimated from series of cases numbering from a dozen to one hundred or more has been reduced, as in Sebring's collection, to less than two per cent. These cases were nearly all severe in onset and some of them desperate. An interesting feature of the method is the uniformity in result as given by various observers in different countries. My personal experience is as yet too small to warrant my presenting in statistical form my results, but thus far they fully confirm the published statements.

Frieser, of Vienna, in a recent article in the *Aerztliche Central-Zeitung*, says of creasote-carbonate in the treatment of pneumonia, that the treatment "has yielded entirely satisfactory and even brilliant results."

Eberson, in the same periodical, states that it cuts short the disease in a most remarkable manner, causing complete and rapid resolution of the diseased focus, and that the sputa and all excreta are voided disinfected, thus lessening danger to others.

Wilhelm Meitner (*Medicinische-Chirurgisches Centralblatt*) writes that there is a "surprising fall of temperature a few hours after its administration is begun; it becomes normal in two days or sooner" and that there is a corresponding subsidence of the other symptoms.

Andrew H. Smith, William H. Thompson, Ferguson, Van Zandt, Stokes, Liegel, Sebring, Cassoute and others have all reported most favorably concerning creasote-carbonate as a specific remedy for pneumonia.

The treatment of diphtheria by means of its antitoxin is so certain in its results and now so generally practiced by all well-informed physicians that its neglect is horrifying. I have written so much upon this question, and presented, to my mind, such conclusive statistics confirming fully the almost innumerable series from general sources that I need say no more than to state that I consider the treatment as per-

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fectly specific; *i. e.*, it practically never fails unless its application is too long delayed.

In glandular therapy the success of the thyroid extract treatment of myxedema is well known. A complete removal of the symptoms is almost certain to follow its administration. The result being made permanent only by the continuous employment of the remedy makes the treatment none the less specific. Other lines of experimentation are promising much.

The suprarenal extract is proving of such value for hemorrhage that we may think of it as almost a specific, in so far as there can be a specific for this symptom. Since October of last year I have prescribed it for six cases of hematuria, all that I have seen, with prompt success in each instance, although the underlying conditions in some of these cases were irremediable.

I have been much impressed by the treatment of scarlet fever with carbolic acid. It was first recommended to me by my old friend Dr. Clay of Moorestown, N. J., whom some of you may have known as a most acute observer. Dr. Wigglesworth, who has published a number of communications upon this subject in English medical journals, claims to have converted scarlatina into a mild disease by means of the administration of full doses of carbolic acid, even to carboluria in some cases. This agent, along with proper hydrotherapy and the iodohydrargyrate-of-potassium or sodium for the later symptoms of some cases, furnishes a most successful treatment. The administration of the carbolic acid must be begun early. The danger from this drug has been grossly exaggerated, or impure articles, which is certain, have been much used. With Merck's or some other equally good first-quality crystalline acid you need have no fear. Although I have used it most liberally I have never noticed unpleasant symptoms of any kind. At the risk of verbosity I repeat, that early administration is the vital point in the treatment, as it is in treating every infection by whatever method. Equally important is it to continue the treatment until the disease is fully controlled. I feel sure that Wigglesworth is correct in his statement that the infection communicated by cases so treated is of slight intensity. He even advocates the exposure of children to this modified scarlatina rather than taking the chances of exposure to a virulent form later. Highly satisfactory as is the homœopathic treatment of scarlatina when compared with general methods, my experience leads me to believe that the carbolic-acid method is much superior to all. The dose is from one to five or six grains, according to the age of the patient, every two to four hours. The acid should, of course, be freely diluted with water. Do not give it with alcohol in any form. Some French observers have

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given as much as several hundred grains of carbolic acid during each twenty-four hours, and insist that a pure acid is practically harmless.

A combination method which we are justified in considering as specific, and which is so well exemplified at Carlsbad, is the treatment of cholelithiasis by means of diet, alkaline waters, etc. Results are governed by the thoroughness with which the treatment is applied. As I have taught and talked this plan for many years, my opinion is based upon considerable experience, which, however, is infinitesimal compared with that of the Carlsbad physicians. My conclusions respecting it are first, that the faithful carrying out of the treatment seldom fails to relieve all the symptoms of the gall-stone disease; and secondly, that most instances of failure are due to a half-hearted application. In respect to this disease it must be remembered that the symptoms are almost entirely due to inflammatory and other secondary processes arising from the mechanical irritation of the delicate mucous membrane lining the gall-bladder and the gall-ducts by the calculi, and that following control of these conditions the calculi once more become latent. Except in unusual cases they are not discharged, and it must be rare indeed that they are disintegrated. In eleven years, during which my records have been complete, I have recorded forty-six cases of cholelithiasis. Of this number five have been operated, nine have been lost sight of after relief in most, and the remainder, with a very few exceptions, have responded perfectly to the treatment under consideration. About twenty per cent of these have had recurrences which have been controlled by a resumption of the treatment. Kehr pertinently remarks in his recent ertraordinary work on the "Gall-Stone Disease" that, "a persistent latent stage is almost as good as a cure." The essential parts of the treatment are, first, the reduction of the carbohydrate element in the food to the minimum; second, the free use of Carlsbad water (preferably hot, and before meals); third, proper exercise to increase oxidation, etc.

The surgeons have been gradually invading the medical man's territory, and with increasingly improving results. It is only necessary to cite appendicitis and gall-stones as examples. Probably the most brilliant of all, however, is the operative procedure recently introduced for the control and cure of Bright's disease. No surgical operation is more positively entitled to rank as a cure for a disease. Although the time since its introduction has been too limited for final judgment, the results, judging from one year's experience, have been most remarkable. My smiles, which were developed when I first began reading Dr. Edebohl's paper upon this subject, must have changed into a most interested expression before I had proceeded far. His paper appealed to me at once, and most powerfully, as I find it did to others, especially to sur-

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geons. Dr. Van Lennep told me that he had observed the development of new blood vessels extending into the kidney where the capsule had been incised during previous operations, and that he was anxious to test the method. To this date I have observed the results of the operation in five cases, two of which were performed by Dr. Van Lennep, two by Dr. Chase, and one by Dr. Northrup. The results have been marvelous. One of these patients died forty-eight hours after the operation. The case was an extreme one and Dr. Van Lennep objected very much to operating, but the patient demanded the chance and we felt forced to give it to him. All of the others have improved brilliantly. These cases will be reported *in extenso* later.

For a variety of conditions characterized especially by asthenia of the nervous apparatus, protracted rest with the employment of various means for the stimulation of metabolism, especially massage, electricity in its various forms, and a proper diet, in short, the rest-cure, are, in the absence of organic changes, quite uniformally successful, and deserves consideration among the specific treatments. Other specific methods, of various character might be considered here, but those referred to are sufficient for my purpose. In reference to this method of treatment I may say in concluding my consideration of the several forms, that it appears as rational to me specifically to treat an infection as it is to remove poison from the stomach or to antidote any which remains in the system.

Perhaps no treatment, however much we may be justified in considering it as specific to a given disease, can ever prove perfectly successful in its application. For one reason, the clinical disease and the bacteriological disease may not be identical. As an example I may cite the case of a young Englishman who was recently received into my service at Hahnemann Hospital suffering from a clinical entity suggesting typhoid fever. After the elapse of one week the temperature came down to about normal and I felt that I had probably been dealing with an influenza, but after forty-eight hours there was a rather rapid rise of temperature and the appearance of cough. This rather confirmed my conclusion that the patient had influenza. Three days later I discovered well marked consolidation of the right, posterior base. The cough now increased much and a copious, glutinous, sticky, bloody sputum appeared. The quantity of blood was considerable, but little if any of the expectoration presented the distinct "rust" appearance of pneumonic sputum. The respirations reached thirty-six—forty, but the pulse did not yet exceed 100. The malar regions were flushed, the tongue was coated but not dark or especially dry, the bowels remained constipated, the abdomen was sunken, food was well taken and borne, and there was little complaint. The clinical condition now clearly in-

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dicated pneumonia following upon influenza. Three examinations by Dr. Sappington, the Hospital Pathologist, revealed pneumococci in small numbers, also an undetermined bacillus in large numbers. The blood had been twice tested for the Widal reaction with positive results. Five days after the evidences of pneumonia appeared a violent general pleurisy set in, with rapid effusion of fluid and aggravation of all symptoms. Bacteriological investigation now determined that the unknown bacilli referred to as present in the sputum were the bacillus typhosus. It gave the Widal clumping. After over three weeks of illness the first loose stool appeared and diarrhoea of a typical character continued until convalescence was established.

This case presents many points of interest, some of which bear strongly upon the question of clinical and bacteriological disease. Some of them are:

1. The suspicion of typhoid in the early stage.
2. The later belief in the influenzic character of the case when the temperature dropped to the normal.
3. The well developed pneumonia later, a few pneumococci being found repeatedly in the sputum, and the complete failure of creasote-carbonate at this stage.
4. Development of acute general pleurisy, with free liquid effusion.
5. Discovery of the bacillus typhosus in the sputum in large numbers, and the securing of the Widal reaction from the same.
6. The securing of the Widal reaction repeatedly, in the ordinary manner.
7. The delay of bowel symptoms until the end of the third week.
8. The absence of the typhoid state except in slight degree near the close of the disease.

The man made an excellent recovery. There can be no doubt but that this was a case of early, and probably primary, development of typhoid fever in the lungs instead of in its usual location in the bowel. Of late we have learned that this is not a very uncommon thing.

It is evident that such a case as this one presents great obstacles to specific treatment from the etiological standpoint. The role of the pneumococcus in this case is uncertain. Possibly its presence was necessary to the development of the pneumonia, that unaided the bacillus typhosus was unequal to the task. Whether this organism did or did not excite pneumonia I cannot with certainty state, as it is so often found in the secretions of the healthy, but the number present suggested strongly that it was an active factor. If so, toxin was producing its peculiar toxic symptoms, therefore, even had we an effective antitoxin against typhoid fever it might not have proven sufficient to control a case of this double character without the simultaneous employ-

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ment for the pneumococcus or other associated pathogenic organisms. An antitoxic drug agent, whose influence is probably for the control of the pneumococcal toxin proved of no apparent value. Fortunately, most infections are sufficiently pure in the early stage to permit of the successful use of a single antitoxic agent. This is well demonstrated in the antitoxin treatment of diphtheria, the streptococcus frequently demanding attention when treatment has been too long delayed.

There is much misunderstanding respecting "specific treatments." Specific treatment is something more than naming a disease and giving a drug, or applying a method labeled as "good for" the same. I was greatly impressed years ago by reading some fourteen columns of a New York medical journal devoted to a consideration of the bromide treatment of epilepsy by that greatest American neurologist, Dr. Seguin. It was practically the treatment of one symptom with one drug. Much can be said respecting the details of application of any of the specific methods of treatment. The following are a few things worthy of note:

1. Certainty in diagnosis, *i. e.*, being sure the case is an example of the disease we think it is, and, consequently, that we are applying the proper specific.

2. Determining that the case is seen early enough to secure benefit from the treatment and, therefore, that it is worth the while to try.

3. Determining that there are no complications or associated disease contra-indications.

4. The proper dose and frequency of repetition of the medicine, antitoxin, etc.

5. Keeping a proper balance between the various parts of a combined method.

6. Securing good drugs, antitoxins, etc.

There is a kind of specific medication practiced according to the homœopathic method which gives admirable results. As indicated, this treatment is suggested by *similars*, and is addressed in a routine manner to well-defined groups of symptoms and to diseases. I will cite only a few of these. Many years since the writer called attention to the value of *gelsemium* as a remedy for the early stage of acute rhinitis. The correctness of the observation has been quite generally confirmed. Given in a good preparation and proper dose, and above all, as in all specific treatment, sufficiently early, it proves quite as specific a remedy for colds in the head as any specific remedy is for any affection. There is no evidence that *gelsemium* acts upon bacteria or their toxins, or in any chemical way, but it is none the less a specific treatment. I also advocated the specific influence of *colchinine* over typical, acute, rheumatic polyarthritis. This has been abundantly proven; but who will explain how it acts? Who will say why the same drug usually controls

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the acute, arthritic manifestations of gout? If the homœopathic principle really or apparently explains the action of these and many other medicines in their role as specific medicaments, why not accept it until a strictly so-called scientific basis for their action can be advanced.

Many will contend that every homœopathic prescription is specific medication, and in a sense this contention is perfectly correct. Many do contend that homœopathy is all sufficient for the treatment of all symptoms and diseases, under all circumstances, regardless of cause or of other methods of treatment. If true, this must be demonstrated, and proof presented. There is still a tendency with a few to contend that homœopathy is a perfect system of therapeutics, and only requires sufficient knowledge upon the part of the prescriber in order to its successful employment. Viewed from the clinical standpoint, however, homœopathy is not a perfect system of therapeutics. It is impossible that any system, in its practical application, can be. Either from inherent weakness of the system, or ignorance, we at times fall short in its application and must then seek the help of accessory methods. If, as some say, this happens seldom to them, still it does happen, and must occur in the practice of every man who is sufficiently educated to know something of the limitations of curative medicine. The overweaning confidence displayed by many is due to lack of careful clinical investigation, and equally important, the recording of it. The failure to recognize the limitation of homœopathy constitutes a grave error, and one which more than any other will justify the position of the old school concerning us. The aim of the great body of physicians to-day, aside from an enlightened class of generous and progressive gentlemen, too few in every profession, is to force us to the exclusive practice of homœopathic therapeutics under all circumstances. However seldom one may find it necessary to depart from its employment, we must insist upon our full right to the entire domain of therapeutics, and to stand upon the same plane as the inappropriately self-styled "regular." The claims of many homœopathists in the past, but of a very small percentage to-day, have fully justified the dominant school in this demand, but representing, as I believe I do, the feeling of the great body of the homœopathic school, I insist upon our full right to all of therapeutics. If one does not weigh words carefully, and this is difficult in following a rapidly read paper, it is easy to unintentionally distort statements and misconstrue the speaker's meaning. This is doubly apt to occur if statements are made which run counter to our established lines of thought and our prejudices are aroused. I have some sympathy with the sensitiveness of many, especially of the older members of the profession, who are "thin skinned" upon this subject of criticism of homœopathy and of homœopathists. Even I am sufficiently old in the prac-

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tice of medicine to remember well the earnest opposition it was necessary to present to the arrogance and oppressive tendency of the old school, and I confess that in view of this fact it is an effort for me to occupy a perfectly judicial position regarding existing medical and ethical questions. Our services to medicine, if they were only of a negative character, demand for us full respect and professional courtesy. I believe we as a body are searching for truth as earnestly, and doing our work as we understand it as faithfully as our old school brethren, and I am sure that while most of us believe that homœopathy was nearly the beginning, it will not prove the end of therapeutics. Valuable as have been the advances made in general therapeutics during the last quarter of a century, homœopathy is to-day the only method at all generally applicable to disease, and we believe it is only here and there as yet put out of action by great mines laid beneath the enemy's works. Let us not claim too much, but remember that homœopathy developed in the beginning of the scientific era in medicine as a reaction against the excessive and unwise medication of the time, and that the great results immediately attained were in a measure apparent only, and that they have been employed too much for their face value ever since. The true student of medicine has, however, very properly discounted them and endeavored to eliminate the percentage related to the cessation of injurious methods. My own observation impresses me that after I have accomplished this, homœopathy is in its results still an exceedingly satisfactory method of treatment, except in a few instances, some of which have been referred to. To deny the possibility of some recent methods being possibly more successful than homœopathic medication, is to relegate therapeutics to the position of being the only branch of medicine in which advance is impossible. Had Hahnemann lived until our day I doubt not that with his progressive and scientific mind he would look with contempt upon some of us little fellows who have spent most of our lives worshiping at his shrine.

As to the future of homœopathy, in which we are all so much interested, I feel that the time has arrived when we must demonstrate its positive and relative value if hope for it to retain even its present position. This can only be accomplished, in my humble opinion, by demonstrating what it can do for diseases. In the past, clinical reports have dealt too much with individual cases and groups of symptoms not having a defined pathological character. Strange to say there are few reports to be found in our literature embracing any considerable number of cases of a single disease. If you were asked as to the success attending the homœopathic treatment of pneumonia, from what sources would you draw your evidence? For Dr. Smith to state that he has "never lost a case," or Dr. Jones to say that he thinks his mortality is

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about such-or-such a per cent, does not satisfy scientific inquiry. Had we not better be up and doing in the matter of developing satisfactory evidence? Personally, the writer has had a staff working for some time upon the statistics of Hahnemann Hospital of Philadelphia, and hopes soon to present considerable statistical material. I call upon all of you gentlemen who are hospital physicians to stimulate your colleagues to unite with you in the same work.

In concluding this paper allow me to suggest that in debating it we endeavor to remember that one's belief is not proof, that glittering generalities prove nothing but ignorance, that mere statements of "superiority" are as "sounding brass and a tinkling cymbal."

DISCUSSION:

J. B. G. CUSTIS, M. D.: When I was asked to discuss this paper I had no idea that I would be called upon to read it. It is with some embarrassment that I enter the discussion when the author is not present, as I am entirely opposed to its teaching and have to criticise it with some condemnation. But inasmuch as it is to go into the Transactions, whether read or unread, I do not feel that, having knowledge of its contents, I would like to see it go in as representing the unanimous opinion of this Section. The last clause we agree with fully; that is, that the simple claim of results proves but little, and, to my mind, its admission throws doubt upon the contents of the paper. Dr. Goodno, as we all recognize, stands among the first of our physicians as a diagnostician, but it is evident from this paper that he is not spending much time in the development of homœopathic methods of treatment. If he treats all his cases of pneumonia by the new specific method, or if all cases in the Hahnemann Hospital are so treated, I do not see how his statistics on the relative value of homœopathic therapeutics can be of use in any competitive trial. He tells us here of the results of his experience of everything recommended by others except those recognized as homœopathicians. He is not so old a man as to have exhausted his experience and the possibilities of homœopathy. I believe that it is wise for us to know all of the methods recognized by others. The homœopathic physician must know all, and have all of the knowledge possible as to methods used, and be familiar with the natural history of disease. He should also be familiar with the limitations of his own treatment, and when he has a case which he recognizes as being beyond hope from any method that he has followed in the treatment of similar cases, he is justified in adopting any new method offered, provided he is satisfied of its scientific claims. That he should do as indicated under certain circumstances, I admit, if it is necessary to satisfy his conscience, but to use the so-called "specific treatment" for every case is not homœopathic, is not necessary and, to my mind, it has never been proven that any of the methods proposed are better than those we have followed. The true essence of a homœopathic prescription depends upon the individualization of the case treated. The symptoms that are characteristic of the disease are of no value whatever in its treatment therapeutically. The symptoms which

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are characteristic of the patient suffering from that disease are the ones upon which we have to base our prescription. When the prescription is based upon that, the method is that of homœopathy pure and simple. We will have to stand by the result, and are willing so to do. Comparisons made on this basis will be valuable, and I have no fear of the results. That the treatment of diphtheria by antitoxin is a great boon to children I am willing to admit; but it has not, as shown by any of the literature of to-day, when taken in competition with homœopathic treatment properly applied, shown any better results. Just to think what it has rid the child of in the way of local treatment, and of the routine treatment without individualization. But compared with the results of careful prescribing after individualization by homœopathic remedies given according to indication, I confess that I am not convinced that the results are better, and I am called an experimenter myself.

So far as scarlet fever is concerned, there is now no necessity for the adoption of the specific method proposed. Scarlet fever has grown milder and milder, until now you almost never have a case that is not so light that you have trouble in convincing the family that the patient requires quarantine. There is no necessity to subject the child to large doses of carbolic acid. Nine out of ten will recover without any treatment, without sequelæ following, and those who do require remedies require that they be carefully chosen. Certainly, large doses of a drug like carbolic acid must lower the vitality.

DR. HALBERT: Without sequelæ?

DR. CUSTIS: Yes, they recover without any sequelæ whatever. I doubt whether it is good policy, as a school, in our public meetings, to have such papers as this one which tells us of all that we can do when homœopathy fails, unless the paper makes plain to us where the limitations of the homœopath are to be found, and enables us to recognize when that limit is reached. I am perfectly willing to give the patient the advantage of anything that is known to the medical profession, but I do not feel the necessity at the present time of experimenting with everything offered. The Doctor has not, nor has any one of those who follow his line, told us about their failures in experimenting with new methods. If some are to be recommended, those that fail to recommend themselves should be reported. Most of us know that there are old-school fads which all old-school physicians use for a time, and then give up. We could all mention a dozen or more in our own experience that have been used generally, only to be cast aside, and sometimes, I am sorry to say, they have been cast aside by the more progressive men of the old school before our energetic youth are convinced of their uselessness. We hear nothing of these failures, only about the wonderful results which have recently been verified, and we only hear of the remedies at one meeting. Certainly, if the specific has been reached it should stay in favor more than one year. If we are going to have reports of the experiments, let us have them of the bad as well as of the good.

The President last night told us that the reason we did not grow as a school is because of the dogmatism of Hahnemann and the bigotry

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of the allopaths. The Hahnemannians of to-day have almost as hard a time as Hahnemann did, because of such arguments and teaching as we have heard here. The reason that we are not growing is not because of allopathic bigotry or Hahnemannian dogmatism, but because his methods and teachings have not been followed by those who teach in homœopathic colleges, and gain their practice by their association with homœopathic physicians. The careful following of the teachings of Hahnemann in therapeutics and the teachings of the same in homœopathic colleges is what we need, so that their value can be proven. I have no fear of the results of any test if representative homœopathists can do the prescribing. We can stand all the dogmatism and persecution possible, if necessary. In our colleges we should teach more of homœopathic therapeutics, nothing else should be recommended. I realize the difficulty the young physician has in prescribing for a case as presented to him if he aims to cover the totality of the symptoms. But if he studies the case with reference to the law of *similia* he will grow independent and get results which will surprise him.

I had occasion this afternoon to give a demonstration of how therapeutics should be studied, using the treatment of glaucoma, a disease which offers but little to the therapeutist. In studying the subject in the abstract I came across a remedy I did not find anywhere in the text-books. We can do that with all diseases. Why should we look to the old school to furnish specifics when our materia medica, perfected, as Dr. Bellows suggests, offers such a fertile field. We will be able to study every case and its symptoms so that the results can be predicted with scientific accuracy. We well know now that we are proud, personally, when we can cure a case by application of the law of homœopathy.

We see all through Dr. Goodno's paper a vein of apology. He suggests the necessity for individualizing cases. Even the old school are admitting that. But let us acknowledge that the whole success of our school up to the present time has depended upon what Hahnemann gave us, both in the law, the provings, precept, and, in addition, an example. I want to insist upon the individualization of a case, and, to my mind, specific medication does not recognize constitutional and personal peculiarities of the patient. Consequently, I cannot believe that the treatment suggested is scientific, and it is far from proven that the cures reported are permanent. They may represent only a suppression of those symptoms which give a name to the disease.

H. V. Halbert, M. D.: I do not wish to take issue with Dr. Custis, but I want to stand up here in admiration of Dr. Goodno and his scientific pursuits. I believe he is not only the greatest student we have in our school to-day, but that he is honest in his investigation. I do not understand his paper, as I listened to it, as meaning that specific medication would in any sense supplant homœopathy; I could not accept that, but I believe it is legitimate for us, as homœopaths, to investigate everything that pertains to the practice of medicine. I, for one, am willing and anxious to learn all I can of any adjuvant or specific treatment that does not take from me the law of treatment in

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which I believe. I think it is well for us, as homœopaths, to pause a little before we seem to condemn everything that leads to the elucidation of new features, new theories and more knowledge. Now, do not understand me as saying that this should supplant or take the place of homœopathic practice. I know full well that we must accept the scientific spirit of the present age. I have stood before students for fifteen years, and I know that they are grasping for this knowledge, and if we do not teach the adjuvants of medicine, in which to a certain extent many of us believe, they will go where they can get it, as we have found our patients have done relative to the use of antitoxin.

I wondered, as I listened to that paper, whether there were not many things of specific character in treatment which we have accepted and adopted for a long time without realizing it. Is not the use of the sponge in typhoid fever, and the consideration of diet therein, in the line of specific medication? Is it not specific to use a hypodermic of strychnia in cases of great cardiac depression, when it is absolutely necessary to tide over a great danger? I cannot for my part see anything that pertains to the adoption and the study of scientific advancement in any way inimicable to the honest attempt of a homœopathic physician to follow the law of similars.

S. H. Aurand, M. D.: Mr. Chairman, I am, as many of you know, quite liberal in my belief with regard to medicine. I believe very much with Dr. Halbert, but I do not quite like the apparent attitude of this paper; possibly it is only apparent. I am very sorry that Dr. Goodno is not here to defend his own paper, and explain fully, so that we might better understand the exact position he takes. The point about the paper which I would object to more than any other is the idea that it conveys to the listener that we as homœopaths must depend upon the old school for such treatment and such drug knowledge as he terms specific. This gives us to understand that the homœopathic teaching and study of drugs and their application, is not quite sufficient to cover all cases, and that it is necessary sometimes to adopt old-school treatment. Now, I know that we are called upon many times, and I believe it is our duty, to use morphine, hypodermic injections of strychnia, and many other things which the old-school doctor is constantly using, and which constitutes his entire armamentarium. But we do not use these drugs as he does; our treatment in the main is entirely different, and therefore we do not adopt allopathic treatment. It is true that we use in common some drugs; this *must* be true, as there is a middle ground, and here we all claim a legitimate right. I consider that the homœpathic physician need not concede one single point of drug knowledge to the allopath. We study drugs more completely and more thoroughly than they do. We study every phase of drug-action from the physiological action of the crude material to the dynamic force of the potentized medicine. They study only several of the principal properties of drugs; such as the cathartic or anodyne properties, and apply them only in material doses. While we study all the special properties and natural affinities and seek to apply them accordingly, free to use any sized dose which the case seems to demand, seeking only to avoid such dosage as will produce

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physiological symptoms, so that we may always have the true symptoms of disease clearly before us, and our treatment therefore based upon pure symptomatology. We claim a superior drug knowledge for the homœopathic physician, and this claim cannot be gainsaid if our various homœopathic colleges will do their whole duty along this line. The homœopathic physician should be educated in all of the natural properties of drugs, their full and complete physiological action, and to this should be added, and is added, the finer symptomatology, which is the special properties and affinities brought about by the proving of the potentized medicine. When we cannot fully classify our cases, or for any other reasons, we have a perfect right to use specific treatment, as Dr. Goodno recommends. But this should come through our own institutions, and is not in my opinion in any sense adopting old-school treatment. We are independent and have a right to all the knowledge we can obtain.

J. Herbert Moore, M. D.: I agree with very much that Dr. Custis has said, and also agree with very much Dr. Goodno has stated in his paper, and especially with the spirit in which he wrote the paper. I must disagree with Dr. Custis as regards antitoxin in the treatment of diphtheria, and agree with Dr. Goodno, and I do that from personal experience in a class of cases compared to the treatment of similar cases years ago, before the days of antitoxin. I have been led to believe in its efficacy, absolutely from experience. Now, as regards antitoxin in diphtheria, we do individualize, Dr. Custis, because I certainly do not use antitoxin in every case of diphtheria. I use homœopathic medicines, depending upon the case and the degree of poison in the system, which I judge by the symptoms presenting, but the minute I see the danger-signal arising, which points on the one hand to malignancy overcoming the condition of the patient, or stenosis of the larynx from a formation of a membrane there, and such symptoms as point to a fatal issue, I then resort to antitoxin, because I place more reliance in it than on homœopathic medicines alone. I have great confidence in *cyanide of mercury* in relieving the general poisoned condition of the system, and in *kali bichromicum,* which I use by putting a generous powder into a half-glass of water and giving it quite frequently. I have great confidence in this in laryngeal diphtheria. I have more confidence in antitoxin treatment than in either of the other remedies, but in my antitoxin treatment I do not necessarily discontinue my homœpathic treatment.

Now, as regards this specific medication that Dr. Goodno speaks about, laying aside its efficacy and coming down to the *modus operandi,* I question whether we are not nearer homœopathy than we realize. Is not this serum-therapy unquestionably homœopathic in its action? Wise men say "Yes," and wise men say "No." But we do not know, I believe, personally that the explanation that appeals more to me as regards the *modus operandi* of the action of the homœopathic medicine is the substitutive action, and if we do get substitutive action in the use of homœopathic drug remedies, in the treatment of these cases that are the result of toxin, poisons introduced in the system, why can we not get in this same way good results from the introduction of

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antitoxin itself? For instance, take typhoid fever; of course, symptoms of typhoid fever are not produced by typhoid bacilli alone, but from toxin that generates from the bacilli, and we all know the effects of *baptisia* and *bryonia* in such cases are due to their action on the toxins, and prevents destruction of the parts when the ulcerative processes threaten in the glands of the intestines. If we could have an antitoxin which, as soon as it was introduced into the system, would cover, as you cover goods with a protecting blanket when water is being poured on the fire, if the *bryonia, baptisia* and other remedies cover in a substitutive way these different organs of the body, so that the toxins of the disease, as you might say, have no territory to feed upon; if we would have a toxin in typhoid fever, as we certainly do in diphtheria, we might do with the antitoxin, and in the same homœopathically substitutive way, all at once what we do consecutively with *bryonia, baptisia* and our other remedies which we use in such cases.

I have studied this question a little as regards homœopathic medicines, and believe perfectly that as regards specific medication, especially relating to antitoxin, we are nearer homœopathy in the true meaning than we comprehend. Now, what is our attitude as therapeutists; the attitude of the general practitioner? We first are physicians; we should first cure our patients. If we can do it by homœopathy, we should do it, and in the great majority of cases I believe we can, but I say, if we have a case that requires some other line of treatment than the homœopathic, it is not only our privilege but our duty to use it. We are first physicians, then homœopathists, and I believe that if we take that stand and follow out the injunction of the Apostle Paul, to prove all things and hold fast to that which is good, then the homœopathic physician is going to be the scientific therapeutist of the coming century. Dr. Custis is right when he says "Let us hold on; let us wait." The old school can afford to go in for these things, for it has no therapeutic guide. Take antitoxin away and their discoveries in a curative way, aside from palliative measures, and they have nothing to work with. They are perhaps the best students in pathology, because their attention in the last hundred years has been on the disease side, while ours has been on the curative side. They can afford to experiment, and while they are experimenting let us stand by homœopathy. But after they had done the experimenting, when they proved the antitoxins, as I believe they have, then it is our duty to accept the outcome of their work, and I believe in this way there will be brought about a better feeling between the two schools of medicine, not by giving up our distinctive name, for *similia similibus curantur,* and the name of homœopathy will never come down. We are here to stay, intending never to surrender. We will acknowledge and accept the excellent work of the old school on the disease side of the picture, and they will eventually acknowledge and accept our good work on the therapeutic side of the picture. We will make an even exchange, each trying the methods of the other, and in that way I believe we are to become scientific therapeutists.

Dr. Custis: I just want to straighten myself out in this matter. So far as Dr. Moore and myself are concerned I think that we agree exactly, and Dr. Halbert is in the same place.

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What I object to in Dr. Goodno's paper is that the paper is presented before the American Institute of Homœopathy, where we come to get the results of homœopathic work and exchange experiences in the use of homœopathic remedies and methods. This paper gives us only the results obtained by men who spend their time in experimenting outside of the school, although affiliated with the school; who are patronized as consultants by the physicians of the country because of that affiliation. That is the only reason that I wished to put myself on record as against the teachings of the paper. No one insists upon the general education of the homœopathic physician more strongly than I do. I believe that with that teaching and the added study of homœopathic therapeutics we can in the near future be the dominant school of medicine.

C. B. Gilbert, M. D.: I do not want to say much, but perhaps I can throw a little light on Dr. Goodno's devotion to antitoxin when I say that he stated in reading a paper before the Washington society that his mortality prior to the use of antitoxin was fifty per cent. I mentioned that to a physician who was not present at the meeting and he said that if that was the case he would have employed some other method. I certainly would not admit that fifty per cent of my cases have died, and I do not blame him for adopting antitoxin, or anything else, that would reduce the death rate to three per cent. I do not for a moment accept the idea that antitoxin is homœopathic for diphtheria. We do not know what it is, but we do know that the manufacturers of this antitoxin inject a horse with the toxin diphtheria because he is immune, as they claim; then the serum of the blood of that horse is injected into a child afflicted with diphtheria; they claim that if 1,500 units are not enough you may give 7,000 units, so that it is, after all, a question of quantity entirely and not a question of drug quality. Whether there is anything in the serum which neutralizes the poison of diphtheria I do not know, but it is evident that reliance on quantity is really the position of the old school in this matter. If it were curative, as we understand cure, instead of increasing the dose all the time up to enormous quantities, after we had given the first dose we should require less and less until it was necessary to give nothing. That is the history of all medicines from the homœopathic standpoint and is the contrary of the history of the medicines of allopathy; the allopaths give their patients all the medicine they will stand, increasing the dose up to the limit of tolerance, but the homœopath does the opposite.

This specific medicine for diseases as diseases without regard to the patient's idiosyncrasy I have no sympathy with or tolerance of. If there is anything in homœopathy, it covers all these conditions, and I think that it is not necessary for us to go outside of the system. When we come to consider our own limitations, not the limitations of homœopathy, as Dr. Moore says, it is our duty to save the patient. If palliation of a disease will tide a patient over and give us an opportunity to carry him along it is our duty and our privilege so to do; but I think that because we have reached our own limitations we should not advocate as desirable something which is entirely contrary to what we have demonstrated for more than one hundred years to be the correct treatment of disease.

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THE RELATION OF THE DYSCRASIAS TO THE PRESCRIPTION

GEORGE ROYAL, M. D.
DES MOINES, IA.

Believing that you get a better and clearer conception of a paper if you know, beforehand, just what idea the author wishes to convey, I will state that my only purpose today is to show that a thorough knowledge of the dyscrasias will so assist us in determining the relative value of symptoms as to enable us to make a more accurate and, hence, a more successful, prescription.

It will be better, also, at this time, to agree upon our definition of dyscrasia. The *Universal Dictionary* gives it as: "An unequal mixture of elements in the blood or nervous juice; a distemperature, when some humors or quality abound in the body."

The *American Medical Dictionary* gives: "Abnormal composition of the blood and humors; a depraved state of the humors." Both of these definitions, you will observe, are based upon the old idea of humoral pathology.

Let us understand by dyscrasia: That element of weakness transmitted from parent to child which, of itself, produces certain definite results, and which renders one more susceptible to the ordinary diseases, and also changes the normal course of those diseases.

Now, let us define the definition. Any of you who have had five years' experience, know that there are individuals who have been "sickly from birth." As babies they were puny, had difficulty with their food, dentition was difficult and complicated by disease. They took cold on the least provocation; any abrasion of the skin or suppuration of a gland healed with difficulty; the eruption of the eruptive diseases did not develop well, and the sequelæ are numerous. If they have diseases they do not follow the normal course. Why? Because, they have inherited this "element of weakness" to which I refer.

We will have time to consider only three of these dyscrasias today, viz., 1, *scrofulosis;* 2, *syphilis,* and 3, *rachitis.* Furthermore, we can only touch a few points, hoping to induce you to make a thorough study of them. In my talk to my fellow-alumni of the New York Homœopathic Medical College last month, I stated the three essentials for a prescription to be: (*a*) Knowledge of the tissues involved; (*b*) knowledge of the sensations produced; (*c*) knowledge of the mode of administering the remedy.

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Following out this idea let us take up and study the three dyscrasias separately.

(1) SCROFULOSIS.

The tissues involved are:

First, the general, or what we term the vital forces. We have all learned from experience that many of the descendants of tuberculous parents possess but little power of endurance. They cannot sustain either mental or physical exertion, neither can they withstand the changes of temperature or other inimical influences.

Second. GLANDS. The most characteristic lesions of this dyscrasia are found in the glands. There seems to be a mild inflammation; then enlargement, which takes place slowly. The glands remain indurated for some time, after which they suppurate and discharge. The suppuration becomes chronic, lasting for months and even years. The glands most frequently affected are the cervical. Following the course of the lymphatics, one after another becomes involved. The discharges often contain caseous material.

Third. THE SKIN. (*a*) *Eczema:* A dermatitis is readily induced. A discharge from the ear, a scratch, vaccination, or any other trivial cause may be the starting-point of the eczema. The discharge is semi-purulent, often forming crusts about the mouth and nose. The lymphatic glands which drain the affected areas are most always involved. The skin becomes reddened and flabby over the glands; sinuses are frequent.

(*b*) *Lichen:* In connection with the enlarged glands we have small papules, not larger than a pin-head. They have this peculiarity, that they are at first bright red, then become pigmented; gradually fading and assume a pale brown color. These papules are found arranged in circles, or segments of circles. There are few, if any, sensations accompanying them. Their course is exceedingly chronic. They seldom discharge. Desquamation takes place, and they gradually disappear, leaving only a stain.

(*c*) *Lupus*: This needs no description; it most commonly appears on the face.

Fourth. THE EYES: The most common affections resulting from tuberculosis are conjunctivitis, corneal ulcers, phlyctenular ophthalmia, and blepharitis.

Fifth. THE EARS: Chronic catarrhal inflammation and otorrhea.

Sixth. BONES: Inflammation and caries, especially about the joint.

Seventh. MUCOUS MEMBRANE: Inflammation of the mucous membrane, followed by chronic catarrh.

The part of the mucous membrane most frequently affected is that of the air-passages. Such patients frequently suffer with bronchitis

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from birth. They are seldom entirely free from bronchial and nasal catarrh; in addition, they suffer from adenoids and chronic tonsillitis.

Eighth. THE BLOOD: There is a tendency to disorganization, terminating in one of the several forms of anemia.

SENSATIONS: Becauses we have a variety of tissues involved and several changes take place in each, we will, of necessity, have many different sensations, such as burning, itching, smarting, throbbing, tickling, aching, trembling, weakness and fainting. For the same reason our modalities are numerous and marked; such as the effect of changes in the temperature, especially to cold or damp; errors in diet; effect of fatigue; emotions; change of position, etc.

(2) HEREDITARY SYPHILIS.

Let us exclude from this discussion the cases in which the children are already diseased at birth. In these you have emaciation; coryza with sanguineo-purulent discharge; snuffles; bullæ on the hands and feet; enlargement of the spleen and liver; hyperostoses of the long bones; gummata of the radio-carpal articulation, *etc., etc.* The majority of such cases grow rapidly worse, living but a few weeks or months. But there is another class which inherits, from a syphilitic father or mother, or both, this dyscrasia. The children of this class may appear perfectly healthy at birth, but beginning about the sixth or eighth week we have changes taking place in the following tissues:

First. NOSE: The mucous membrane, cartilage and bones of the nose are affected. We have the coryza; the purulent discharge, and snuffles. The discharge changes to sanguineo-purulent; and then, showing that the bones are being destroyed, we have the flattening at the bridge of the nose.

Second. SKIN: A peculiar eruption, especially about the nates. The patches are brown, or brownish red. They have a well-defined border. If care is not taken to keep the parts clean and dry suppuration takes place and ulcers form, the discharge from which is sero-purulent. You will find fissures about the lips and nose. These leave small cicatrices or scars. You may, also, find onychiæ and suppurating ulcers about the finger-nails.

Third. NOTCHED TEETH, OR "HUTCHINSON TEETH:" This is considered characteristic of hereditary syphilis.

Fourth. THE BONES: Irregular development. Disease of the long bones and cartilages, with separation. Suppuration and caries are quite frequent.

Fifth. EYE: Iritis and keratitis.

Sixth. BLOOD: Finally there comes malnutrition, hemorrhages, marasmus; the child has a harsh, piercing cry, a sort of moan. If such a patient outlives its childhood it will be undersized; have the turned-up

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lip, prominent forehead, depressed nose, etc., characteristic of the dyscrasia.

SENSATION: Aching, burning, itching and smarting. The most marked modality is the aggravation at night of the aching in the bones, when getting warm in bed, and of the so-called rheumatic pains just before a storm or change of weather.

(3) RACHITIS.

We must all remember that a large percentage of those suffering from either scrofulosis, syphilis, or rachitis have acquired rather than inherited the disease. Of the three dyscrasias the rachitis has the smallest percentage of the inherited. Some even claim that the disease cannot be inherited in the true sense of the word, but those who have had the most experience realize that the mother who is ill-fed, who lives in unfavorable hygienic surroundings, who nurses a child during gestation, *etc.*, is surely in condition to give birth to a child possessing the "element of weakness" mentioned in our definition. Then, again, the disease appears in so many children, at such an early age, as to preclude any other cause.

TISSUES INVOLVED.

First. BONE: The affected ones are those of the skull, ribs and long bones. The bones of the skull may escape if the disease sets in after the eighteenth or twentieth month of the child's life, but nearly, if not all, of these cases are of the acquired variety; they should not be considered in this discussion. In the cases showing the disease after birth the bones show areas of delayed ossification. In some places, there is no bone at all. This gives rise to deformity.

The frontal and parietal eminences are exaggerated; the top of the head is flattened; also, the occiput. The result is, the box-shaped head. The rachitic bones are soft and spongy.

The cartilages at the epiphyses proliferate rapidly, forming thick, soft, bulging masses. The periosteum is thickened. Meanwhile the bone is deficient in organic ingredients from one-half to two-thirds the usual amount.

Second. LIGAMENTS AND MUSCLES: I mention these structures, but it is only those which are attached to the diseased bones which are affected. They are affected in the same manner as is the periosteum. It is very rarely that other tissues are involved.

SENSATIONS: Please pay special attention to these, and to their order of development. You may be called several days, and even weeks, before any changes in the bones are apparent. The mother will tell you that "her babe has morning diarrhea, that the stools are offensive, light-colored, accompanied with much flatulence; that the child gags a great deal, and sometimes vomits." This is a clear case for *podophyllum,*

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which you give, and promise a speedy cure. If you, instead of another physician, are called a little later the mother will say in addition, that "Baby does not want to be moved; he seems so sore to touch; he sweats profusely, and the odor is sour and musty. He seems to have inward fever, for he drinks a great deal. He seems dull, languid, and does not move his limbs much, but I guess that is because it hurts him to move, and he has nose-bleed every now and then." Surely, this is *byronia*(?) and so *byronia* supersedes *podophyllum,* so that the baby can move with more ease. A few days later you are recalled. There has been a change; new symptoms have appeared; the mother says, "Baby is so peevish; so irritable; so restless. I really believe he had inward spasms last night, for he screamed in his sleep. Don't you think there are some teeth coming, Doctor? His gums seem sore, and his stools now contain undigested food, particles of milk mixed with green and yellow." *Chamomilla* 30*th* has cured more cases with that group of symptoms than any other drug in the materia medica, and it is given. Yes, Doctor, but it will not touch this case.

Three or four weeks have been lost in this manner, and now the enlargement of the bones at the ribs, the ankles, the wrists, and of the cranium, begin to manifest themselves. Any tyro can now see that such a superficial, quick-acting remedy as *chamomilla,* or even the more deeply acting drugs, *podophyllum* and *bryonia,* never did, nor ever can, cure such cases.

What should have been given? Were not the symptoms found on the three different occasions the symptoms of the three drugs given? And are we not to prescribe for the symptoms, rather than for the patient or the disease? Surely, my friend, they were symptoms of the three drugs mentioned, and you should prescribe for the symptoms, but they were not the *totality* of the symptoms in this case, and that is the point I am trying to make to-day. What was wanted was a group of drugs having these same symptoms, and, in addition, having a special *affinity for* and *action upon* the *bones.* Such a group is composed of *phosphorus, calcarea,* and their compounds—especially *ferrum-phos.* and *calcarea-phos., calcarea-carb., sulphur, kreasote, asafetida, fluoric acid, etc.*

I could, did time permit, draw many similar comparisons, for illustration, between remedies indicated, and contra-indicated, for the other two dyscrasias, for example, between *aconite* and *iodine, belladonna* and *ferrum-phos., etc.;* but I will content myself with one more.

I was called to see a little girl eight years of age. The mother and father were both present, and looked healthy.

I elicited the following symptoms:—The patient had been as well as usual till the day before, when she went to ride; being a cold day, she

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became chilled. During the night she became hot and restless; also, thirsty; the temperature was 105 1-5; pulse 148, firm and wiry. The skin was very hot and dry. I was in a hurry, and gave *aconite* 30th, with orders to discontinue when the skin began to moisten. This was in the morning. I returned in the evening and found no improvement. On putting the thermometer in the axilla I discerned cicatrical tissue, and learned that she had had several attacks of adenitis, with suppuration. I also learned that her mother was the only one of four children not tuberculous. I changed my *aconite* to *iodine* 12th, and the next morning the temperature was 99 1-5; pulse 105. The next day she was sitting up. I will not put you to sleep giving you the symptoms of each remedy. I have written out those which I have verified, and you may read them in the Transactions. I will close by asking you to make the family and personal history of your patients not only a part of your symptomatology, but the *most prominent part.*

REMEDIES.

ARSENICUM.—When there is a well-developed cachexia; rapid emaciation; marked debility; chronic diarrhea; stools watery, dark-colored and offensive; a very irritable stomach; frequent vomiting. The most marked symptoms are the scaly eruption and the aggravation after midnight. Arsenicum is all the more indicated if, with this group of symptoms, or a part of it, you find what you suspect to be epithelioma.

ARSENICUM-IODIDE.—When, in addition to the symptoms given above, I find a patient suffering from inflamed and unhealthy glands, and a scaly eruption which is very proliferous, I prefer the *Iodide-of-arsenic* to the metal. *Iodide-of-arsenic,* 6x, three times daily, cured a girl of eight years, whose father had syphilis before she was born. The mother saved the dry, fish-like scales which had been rubbed off the body during twenty-four hours. There was nearly an ounce by measure. Almost all the lymphatic glands were involved.

CARBO-ANIMALIS.—A baby of eighteen months, whose father had had syphilis five years before, showed symptoms about five weeks after birth, presenting the following: Face earthy; emaciated; on which were several spots of a copper-colored eruption. Gums swollen and bleeding. There seemed to be distress after feeding. Abdomen greatly distended by gas. Stools hard and lumpy. Sleep very restless. There were a few spots on the back, abdomen and limbs similar to those on the face. On the buttocks, if the diaper were not changed at once after urination, the spots became inflamed, enlarged, and suppurated, leaving ulcers as large as a nickel, which healed very slowly. This case was completely cured by *carbo-animalis.*

CARBO-VEGITABILIS.—When the eruption is finer and there is more tendency to hemorrhage, I use *Carbo-vegetabilis* instead of *Carbo-ani-*

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malis, providing we have most of the symptoms given under *Carbo-animalis.*

MEZEREUM.—When we have inflammation of the external margin of the nostril, with a fluent coryza, yellow in color, at times bloody, this discharge causing soreness of the integument wherever it touches; with eruption on the face and scalp which is red; a discharge which forms a crust beneath which accumulates a large quantity of pus; pains in the bones of the face, especially the nose; when the teeth decay rapidly, and especially when the pains in the bones and teeth are relieved by cold air; when we have burning in the fauces with dryness and hoarseness; when the burning is relieved by cold air, and when we have diarrheic stools, sometimes bloody, sometimes watery; periosteal inflamation, especially of the femur and tibia, I use *mezereum.* I always feel surer of this remedy if I find brown spots on the chest and arms left after the scabs have been removed and the ulcers healed.

CALCAREA CARBONICA.—The symptoms of this remedy you will all recognize. Your fat, chubby, light-complexioned, soft-boned baby or child, with a skin that is rough and flaky (what Frank Kraft calls a "pie-crust" skin). A constant discharge from the nostrils, which is brought on by the least exposure to cold or wet; whose stomach is always sour; whose stools are always undigested; whose glands are always enlarged, and whose pillow is wet with perspiration from the head and shoulders. The bones of the skull are always soft, and yet they are thick, as well as spongy.

CALCAREA PHOSPHORICUM.—This has many of the symptoms of the carbonica. The bones, however, instead of being thick and spongy, like *carbonica,* are either thin and brittle, like tissue paper, or thick and soft in some spots while wanting in others. The child's neck is usually too small and weak to support the head. The bones of the leg will not bear the body. The stools are of green mucus, bad odor, undigested; flatus abounds. The first symptoms which appear are those of malnutrition, such as vomiting of undigested food, colic, etc. If the bones have been bruised or wounded they do not heal readily. The children are always fretful, having many of the symptoms of chronic hydrocephalus; there is usually a good deal of temperature with these conditions.

CALCAREA-IODIDE.—With this compound you find more glandular involvement than under either of the others. With many of the symptoms of *calcarea-phos.* and *calcarea-carb.* you find the typical "pot-bellied" baby. The mesenteric glands are swollen and hard; the other symptoms of indigestion, emaciation, *etc.,* appear later. The manifestations of the glands appear first.

KALI-IOD.—This remedy, so much abused by the old school, is certainly homœopathic to certain forms; we have intense sticking, digging

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pains in the head, which are aggravated on stooping, associated with a profuse, acrid coryza, which is thin and watery; profuse saliva, with swelling of the glands of the neck; raw, sore pains in the throat; swelling of the knees, with boring pains, worse at night; also, with numerous neuralgic symptoms which are worse at night, compelling the patient to get out of bed. This, together with eczema, pustules, vescicles, even bullæ on the hands and arms, the latter of such size as to leave cicatricial spots, are the indications which have led me to give the *kali-iod.* I have never found it necessary to use anything lower than the 2x to obtain the desired results in such cases.

KALI-BICHROMICUM.—The child of *kali-bichromicum* resembles that of *calcarea-carb.* in its make-up. There is susceptibility to cold air. Inflammation of the mucous membrane of the nose and throat are generally the first symptoms to appear; following this comes the round, deep, punched ulcers. From the mucous membrane we get the tough, tenacious mucus. Several of the ulcers may be located so near each other as to give the appearance of a large, flat ulcer, over which the secretions dry, forming what is known as the "scab," or "clinker." The stomach symptoms are frequently marked, there being nausea and vomiting. There is also the thick-layered skin, with a tendency to elephantiasis.

HEPAR-SULPH.—The aggravation from cold, of most of the symptoms, is, to me, the key-note. Chronic suppuration, with the sharp, splinter-like pain, chronic catarrh, with muco-purulent discharge; chronic eczema, with its offensive discharge; soreness everywhere, but especially of the bones, the disgust for food, especially fat; the craving for anything sour, like sour wine or vinegar; the gnawing pains in the stomach. The bad odor of all the discharges, are my indications for *hepar.* Sensitiveness to touch and cold air are, however, the most prominent.

THUJA.—I believe this remedy is sadly neglected in these conditions. We have been in the habit of giving it for cauliflower-excrescences and for certain nervous affections, but we are liable to neglect it in certain forms of headache in which the pains are stabbing, violent, followed by extreme soreness; also, in severe forms of iritis and keratitis, where we have excessive photophobia, opacity, gummata, where the pains are worse at night and worse in damp weather. There is also a good deal of discharge from the nose, which is thick, green, mucous, purulent, sometimes bloody. Such patients generally suffer from chronic diarrhea; the stools are copious, forcible, expelled with gurgling. Polypi of the vocal chord, which gives rise to persistent cough, also polypi of the nose, are frequent indications of *thuja.*

GRAPHITES.—For skin affections in these dyscrasias, also for functional disturbances, especially of the female, *graphites* is one of our

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most important remedies. The eczema is moist, glutinous, and forms scabs, often taking the form of herpes, which leaves a soreness and painfulness of the nerve along whose course the herpes appears. The stomach-symptoms are also quite marked, and, especially, the symptom of neuralgic pain which comes on some hours after eating and is relieved by warm, and aggravated by cold, drinks. In the female we have the delayed menses or the scanty menses, with leucorrhea, which, at first, is quite thick, but afterwards becomes watery. Such patients generally grow fleshy. We have also the symptoms of mental depression, weeping, vertigo. Induration of the ovaries and liver are, also, conspicuous symptoms.

I will not take up your time to mention the symptoms of *staphysagria, silicea, sulphur* or the *mercuries,* not because they are not as important as those already named, but because they are more frequently remembered and used in the dyscrasias than are those which I have already given.

DISCUSSION:

W. A. DEWEY, M. D.: This question of the different dyscrasias, which Dr. Royal has denominated scrofulous, syphilitic and rachitic, seems to me, in a way, to be a restatement of the old theory of Hahnemann—the psoric theory.

There is one point which should be brought out forcibly, and that is that psora (if we may so call this first and last of the dyscrasias) may be acquired as well as inherited, and much can be learned from the lesson that the doctor gave in illustrating his cases; that is, in getting at the totality of the symptoms we should not be satisfied with a mere superficial totality, but go down into the history of the case from start to finish, and get the true, real totality. His illustration of the last case, where he prescribed *aconite* when *iodine* was the proper remedy, recalls to my mind the use of *belladonna* or of *helleborus* in a case, for instance, of what is termed tubercular meningitis. *Belladonna* produces frequently, in its pathogenesis, a picture of a case with dilated pupils, boring the head into the pillow, a red face or a pale face, screaming out in sleep, grating of the teeth, and all of the symptoms that belong to a well-developed case of tubercular meningitis; yet I do not believe that *belladonna* will cure such a case. We have to resort to remedies much deeper-acting than *belladonna,* remedies that reach the dyscrasia, remedies that reach the psoric constitution of the patient. Therefore, although different pathological conditions will produce similar symptoms, we must go deep into the history of the case in order to prescribe intelligently.

CHAS. MOHR, M. D.: Mr. Chairman, I heartily endorse the views expressed by Dr. Royal in his essay. Exception may be taken, however, to the "speedy promise of a cure" after the exhibition of *podophyllum* in the related case. Promises of a "speedy cure" are usually to be avoided. What one of us who has had any clinical experience does not realize the fact that the practice of medicine is always, and always

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will be, problematical. Why, you find at times in the most common acute diseases symptoms that are very charactreristic of certain of our remedial agents, and we prescribe them with the belief that they are going to do good. though our diagnosis as to the disease may be reserved, and we must wait one day, or two days, a week, or sometimes two weeks, even in an acute affection, before we can positively assert that we have a certain nosological disease to treat. Then, what are we going to do? What is there to do except to prescribe for the presenting symptoms and remove them as they arise? Every time you prescribe according to the homœopathic system, if a remedy is well indicated by the subjective and objective symptoms, you are going to make the case more amenable to subsequent treatment, if it is going to be a continued case. I believe that every time you prescribe the homœopathic remedy you are going to do good; therefore, it is far better to prescribe for the pronounced symptoms and remove them, if it is possible, even before you may know the exact name to apply to the disease or before you may be able to distinguish the underlying dyscrasia. I think that is a safe course to take, rather than to wait a week, or a month or two, or longer, as you must in certain dyscrasias, before you apply any homœopathic remedy. Even in dyscrasias, something extraneous may arise which sets to work a train of acute symptoms. There are symptoms of suffering, symptoms which may mean much or that may mean little. Usually, however, if well defined, they are enough to indicate a homœopathic remedy, which should be exhibited, and then the development of the case can be awaited, the deeper acting or "constitutional" remedy prescribed, which may act as a complementary remedy to the one first prescribed, and so effect a cure. Now, that is the principle of homœopathic treatment, as I understand it, and as I think Hahnemann taught; we cannot, as some persons believe to-day, have a specific remedy for a specific disease, which you can give always and every time in the beginning of a disease prescribed for by its name, with the assurance that you are doing the best thing for the patient. I do not believe in that.

W. H. Pulford, M. D.: If we study the materia medica as we ought to—and this is a problem that should be presented to the society generally—we should learn to differentiate our remedies, and learn to read the case properly before we apply the remedy. In so doing we study the dyscrasia in connection with the symptoms that present themselves, objective, and subjective, and, being properly conversant with the remedies, we are able from experience to prescribe more correctly. I will cite two cases: I was called one day to treat a child that was very cross, and furnished all the symptoms proper for *chamomilla*. I hastily prescribed without studying the case as closely as I should, and when I went the second time, I found I had not done the amount of good I expected. I learned then that the child had been cross all night, but not very cross during the day, and I began to ask questions. The mother immediately interposed and said that the baby was very much afraid when put down, which suggested to me two remedies, *borax* and *gelsemium*. When I examined the mouth and the anus I found that the child had aphthæ. I gave three powders of the sixth trituration of *borax*, and that settled the case. The child rested well all night and was better next day.

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A. B. SPINNEY, M. D.: I have the most high commendations for the paper. I believe it is the keynote in the treatment of disease. Experience of forty-three years has long ago convinced me that we very often prescribe superficially for symptoms when, if we go deeper into the case, we will find a pathological condition that our remedies, studied carefully and thoroughly, will meet, not prescribing for symptoms which protract the case from day to day. Dr. Mohr's ideas I cannot endorse. I feel that one may carry this method too long and lose the effect of such deep-acting remedies as *iodine*. I have found when prescribing hurriedly without consulting my materia medica carefully, if we prescribe for fever, for symptoms that the remedy covers, only those symptoms, but not the real pathological condition. We know we have far-reaching remedies in the *iodides*, in *arsenic*, in *sulphur*, and in those which eradicate the dyscrasia. When the dyscrasia is removed, the symptoms disappear as by magic.

J. B. G. CUSTIS, M. D.: Mr. Chairman, Ladies and Gentlemen:—The question that is presented to us by this paper is how best to teach materia medica. Dr. Royal has given us a good illustration of his way, and shows us how to get at the proper remedy for a case according to his method. He embodies many of the most important points in prescribing. I would call his method the best offered for the teaching of how to anticipate symptoms. This is entirely legitimate, but it requires experience, and shows where the older and more experienced physician has the advantage of the younger practitioner.

Each disease has its history, as each drug has, and the two histories taken together give the physician the totality of the symptoms, and from this, under the law, he knows what to do. The history of drugs makes it possible to cover that totality. The covering of the totality by the physician is not always possible, but if a cure follows his prescription study of the remedy which has cured will show that the totality has been covered. The essence of good homœopathic prescribing is in the individualization of each case. We all anticipate symptoms, especially those who observe closely and profit by their experience. Some will tell by the character of the pulse that hemorrhage is imminent in case of a fever, and prescribe accordingly, knowing the remedy that will most likely be called for should the patient have a hemorrhage. This method is legitimate, and generally efficacious. Hahnemann teaches all of these things. He tells us to "remove the brake," as Dr. McClelland suggests, when the carriage won't go. In other words, when remedies carefully prescribed do not act there is a "brake," and he tells us that under certain circumstances he gives *sulphur* to remove the same. I do not believe in giving *sulphur*, unless it is indicated by the condition of the patient. Other remedies as well as sulphur will remove the "brakes" which interfere with the action of remedies upon the system. This "brake" is what the doctor means by *dyscrasia*. When it is subdued, the totality of the symptoms becomes plain, and the remedy indicated is apparent.

H. W. PIERSON, M. D.: This paper opens up for discussion a subject that lies at the very foundation of all our work. The constitutional cause for disease, or *dyscrasia*, must receive due consideration before we

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can hope to have cures follow the application of our remedies. A failure to recognize its causal relation will find us going over the same conditions from month to month and from year to year without any perceptible improvement in the general health of our patient. This experience is not peculiar to our day and generation. Hahnemann followed the same line of investigation during his early experience with homœopathic remedies, but instead of conceding the limitations of his remedies he sought for a deeper and more fundamental cause for disease, and after patient, but persistent, efforts, discovered the real cause for his failures to lie in the three misams, psora, sycosis and syphilis. The paper simply emphasizes the importance of this deeper study, and should be earnestly commended to every student of medicine. It matters not what names we may affix to these conditions, so long as our study of each case impels us to give due consideration to the subject of *dyscrasia.* While we are seeking for fundamental causes we must, at the same time, keep in mind the more prominent symptoms brought out by the exciting cause, for the reason that many of them will disappear as soon as the cause has been removed without the use of remedial agents. But when the history shows that certain exposures will almost inevitably be followed by certain results, then you have evidence of a dyscrasia, with the natural tendencies to disease manifestations in this particular individual. Your treatment must, therefore, be directed primarily to the removal of these tendencies by such treatment as shall be indicated in the true totality of symptoms.

H. C. ALLEN, M D.: Mr. Chairman:—Hahnemann's experience was phenomenal, and he gives it to us in very terse and emphatic language. He met the same obstacles we have met when he was getting out of allopathy. We are practicing just now what Hahnemann did for many years, prescribing superficially. As Dr. Royal just told us, he gave that baby *aconite;* it was not the remedy, and did not do the work. Why? It was not the *similimum.* Hahnemann said, after being disappointed for many years by his cases continually relapsing, that he began to study this subject; and after twelve years of hard work, as only the closest observer the medical world has ever known could make, he found there was a dyscrasia. He did not name them as did Dr. Royal; he classed scrofula and rachitis under the name of psora. The name does not matter; he says that these constitutional ailments will remain latent until some peculiar excitement, some exposure, either mental or physical, is experienced. When the patient is exposed and the exposure brings on an acute outburst, then, he says, we have the fevers, and these fevers, or these diseases, are only outbursts of psora, the chronic dyscrasia, and we make a mistake in treating these cases, as we do not follow Hahnemann's advice. We should take the symptoms of the case carefully before making a prescription. We run in and make a prescription for "fever," simply because the patient has fever. We give *aconite, belladonna,* or something else. We do not go to the bottom; we do not sit down with the patient and write out the symptoms carefully, as Hahnemann instructs us to do. If you do not know what to give, give the patient the benefit of the doubt, and do nothing until you do know. Carry a little of the second-best remedy in the materia medica in your

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pocket, *saccharum lactis.* Put that in a glass of water, and give it to the patient every half-hour or hour, and if you do not know what to give, go home and find out. You can do that; there is not one time in fifty that you will find a patient so sick that you cannot go to your office and find the remedy.

J. D. Buck, M. D.: It is all very good, and I can endorse every word said. Your dyscrasia is all right, your symptomatology is all right, your totality of symptoms is all right, and the pathogenesis of your drug is all right. The last speaker referred to beginning at the foundation. That is the only reference I have heard to the point I have in mind. We are dealing in all these subjects with results. We are handling the effect upon *matter,* and the perverted portion of energy. I would not have you neglect the study of disease, or pathology, or materia medica, but I would have about ten times as much of the study of *mind* as we have now, and unless we do that—and we are doing better to-day than ten years ago—we will have more and more to face those (to us) phenomenal effects actually obtained by the Christian-scientist and metaphysical-healers. You can't ignore their results. In our medical colleges and societies, and among the individual members of the profession, we scarcely have even the name of the study of psychology. Why, all the psychology we have is with the soul let out, and notwithstanding our high potencies, we are materialists; and what I want to advocate and urge upon this Institute is the study of medicine from a scientific psychical standpoint, so that we will know the character of forces affecting the system, and then I think we will deserve the name, much more than we do now, of scientific physician. We will study the science of life and practice the art of medicine.

C. W. Sigrist, M. D.: There is a proposition in geometry that the whole is equal to the sum of all its parts. Dr. Buck has not covered all these parts. A part of the whole is the vital forces, and a part of the subject he has not covered is the feeding of human beings. Let us look more into that, our vital forces will be better, and we will not have occasion to look into our materia medica so much.

George Royal, M. D.: I must differ with my friend, Dr. Mohr. I have been taught, and my experience has carried it out, that every time you give a remedy that is not the indicated one, that is not the *similimum,* just so often do you diminish the chances of a cure.

Dr. Mohr: I believe that; I was making an argument and I had not the time to develop it.

Dr. Royal: I am glad that you believe it. I had only fifteen minutes to present this subject, which should have taken fifteen hours. This is only on one point. Dr. Buck's is on another, and all that I wanted to show you here to-day was this: That, you cannot get the totality of symptoms without taking these dyscrasias into consideration. That is all. I had the pleasure, last fall, in the city of Des Moines, of meeting one of Hahnemann's patients, and I spent a most delightful evening

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in his company. This patient, Mr. Young, went to Paris to be cured of what had been diagnosed as tuberculosis by as good a man as Dr. Clark, of London. Mr. Young said: "Dr. Hahnemann came; he made me take off every bit of my clothes; he had the window-shade lifted so that he could see the appearance of the skin; turned me around and around; he listened again and again to my lungs, and percussed, and asked questions, the answers to which he wrote out. He spent six or seven hours taking the case, and then he said, 'I will see you again in the morning.' He repeated the examination in the morning, and after spending twelve hours, in all, said, 'Thank God, you have come in time to be saved, though late.' Then he gave his prescription." You see Hahnemann took everything into consideration. Mr. Young stated also that Hahnemann regulated his diet and his exercise, and wound up his story by thanking God that he was alive and fairly well at ninety years of age, the result of his visit to Dr. Samuel Hahnemann.

These dyscrasias, if we understand our symptoms and remedies, and why symptoms are produced, brings up the question of feeding. A certain remedy needs a certain kind of food. You must not give starchy food to a child who needs *aconite,* as there is no saliva.

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WHERE SHALL WE BEGIN TEACHING THE HOMŒOPATHIC MATERIA MEDICA—WHAT SHALL WE TEACH, AND WHERE SHALL WE STOP?

S. H. AURAND, M. D.
CHICAGO

First, Where Shall We Begin? The beginning of any project or undertaking, it seems to me, deserves, according to its importance, serious consideration, for upon the beginning, many times, depends the success or failure of the work.

I am convinced that Samuel Hahnemann, in promulgating and developing the homœopathic law, fully believed that it was just what it has proved to be, *viz.*, a natural law containing its own truth, and, therefore, its own limitations. All specific truth must remain within the bounds of its own specific law. Truth may be stretched or warped or attenuated to that degree where it becomes an unreliable truth, or an absolute falsehood. Ice may be attenuated into water and water into steam, but each one of them will have wrapped up within itself its own specific power, truth and law.

Is the homœopathic materia medica based upon a scientific law? Does it contain its own specific truth? Has it limitations, as all law and truth must have to make them law and truth? Or, is it a peculiar sort of a hybrid, capable of being warped and dovetailed and twisted and stretched and expanded and distorted into all sorts of size and shape and consistency, and still retain its power to act as a specific law and its influence as a specific truth? These are questions which naturally arise in the beginning of the study of this important branch. I believe, therefore, that the first necessary step in teaching the homœopathic materia medica is to expound the law which governs our practice. The student should understand the true nature and scientific application of the law of *similia similibus curantur*, which means that like things are cured by like.

It seems to me that we as teachers, many times, fail to understand the real importance of this first step, and without understanding the whole scope and specific action of the law, attempt in a general way to give it to our students. The result is that they never have quite a logical understanding of the underlying principles of homœopathy. And they are therefore unable to harmonize the different phases of later instruction, which includes a mixture of symptoms, with it. This difficulty with the two following insurmountable obstacles rising before them, *viz.*,

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the great number of important remedies on the one hand, and the immense mass of symptoms on the other, is sufficient explanation as to why confusion reigns within the ranks of the materia medica department, and why our students and graduates are complaining of their inability to master the homœopathic materia medica, and are seeking allopathic quarters to obtain definite and limited drug knowledge. In the light of all the definitions of science given by our recognized lexicographers, and according to the generally accepted meaning of that term, we are driven to the conclusion that the homœopathic materia medica, as it exists to-day, is an unscientific book, composed of a large mixture of confused scientific truths. Webster says that "Science is the comprehension and understanding of truths or facts. Truth ascertained, or that which is known." He also says that "Science is knowledge duly arranged and referred to general truths and principles on which it is founded and from which it is derived: philosophical knowledge: profound knowledge: complete knowledge: true knowledge." Thomas, in his *Medical Dictionary,* says that "Science is the knowledge of many persons methodically digested and arranged so as to become attainable by one." Now, between the present arrangement of our materia medica and these definitions there seems to be a want of harmony, and if this seeming want of harmony is real it means that we do not come up to the generally recognized and accepted standard. Is our materia medica, in its present form, and as a whole, that which is known? Or is it more properly that which is conjectured? Is it comprehended and understood? Is it duly arranged and considered as having a certain completeness? It is true that our materia medica is made up from the knowledge of many persons. But is it true that it is methodically digested and arranged so as to become attainable by one? Now, in the light of the above definitions, is our materia medica a scientific possibility, or a sealed perplexity? Does it conform to or harmonize with our therapeutic law? Ask me what you will and I'll find it somewhere in some of our books on materia medica or general practice.

Let me cite you a few of the extremes. If you wish to replace a dislocated uterus, give a dose of *sepia,* and your patient will soon feel this organ lifting itself back into normal position. If you wish to produce podalic version, give your patient a dose of *pulsatilla* and the babe in utero will immediately turn itself upside-down. In another homœopathic text-book we find the following: "In continued malarial fever *quinine* must be given in large doses, 20 to 30 grains daily, nine grains, morning, fourteen grains, evening." "If you desire *quinine* to act promptly give one or two grains of blue-mass, to carry off the unhealthy secretions." Now, I do not wish it understood that I deny the possibility of the existence of some scientific fact in both of these extremes. But to

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the logical homœopathic student they seem more ridiculous than scientific. And unless he thoroughly understands the homœopathic law they would lead to mental confusion and a loss of faith in the system.

While this homœopathic law is profoundly scientific, clean-cut and specific in its action, yet, in order to avoid confusion and misunderstanding, its application should be taught to the student in two distinctly separate classifications. I have profound faith in its accuracy and power, if properly applied in accordance with either classification. I believe that in our study and handling of drugs, material medicine should be held distinctly separate from that which is termed its "spirit-like" force. Each is of sufficient importance to constitute a field of its own. And both are applicable in accordance with the homœopathic law. Each power, I believe, should be separately proved and the record kept distinctly apart from the other. If our law means anything, it means everything. It must be wholly right or wholly wrong. If like is cured by like, then it naturally follows that only those symptoms which are found in disease, that can be produced by a "spirit-like" force in a drug, can be cured by the same "spirit-like" force. And those which are produced by a material drug are also cured by a material medication. Each power should be thoroughly tested and its limitations sharply defined. It is only by proper classification and closely defined limitation that any collection of scientific facts can constitute a scientific whole. This, too, would have a tendency to remove all of the friction which so prominently exists in our profession to-day. Separate colleges need not then be formed on account of separate views on this point. It would also relieve much of the odium which has wrought great injury to our system of medicine. And I believe would stamp our school as a more ethical and logically scientific institution.

Second. What Shall We Teach? Which of the six hundred drugs contained in the homœopathic pharmacopeia shall we select to form the ground-work of our materia medica instruction? Is it at all important that the various medical colleges of this country are uniformly engaged in teaching the same set of drugs at the same time? Is it not true that scientific classification has been sacrificed for alphabetical convenience? Are we to understand that this great body, The American Institute of Homœopathy, recommends, as it would appear, that we begin our course of instruction with *abies canadensis* and end with *zingiber officinale?* And that we attempt to teach all that goes between? Or shall we gather the idea that the pharmacopeia is simply calculated for a reference-book, and not intended as a guide along this line? And that each instructor is left solely to his own judgment, or, at most, each medical college to its own judgment, in the matter of deciding what remedies should be taught?

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Is concentration of thought, uniformity of effort and harmonious action worth anything in lending strength and support to an institution or system? Does it not stamp it as a complete, unified, scientific whole? And does not the lack of this tend to weaken and confuse and destroy even that science which it has obtained?

It is quite possible, but perhaps not probable, that twelve of our homœopathic medical colleges might each give a course of instruction on the homœopathic materia medica, selecting fifty drugs for the groundwork of their course and no two teach the same set of remedies. This, I understand, is an improbable extreme, but, however near you may approach it, just in that proportion you will lack uniformity of purpose and concentration of effort, out of which must come an intermingling of mixed scientific truths, and as a result an inadequate or defenseless strength. Each class of medical students must necessarily be impressed with the superior healing qualities of the remedies which it has been taught, and will therefore prescribe them to their patients, talk about them in our societies, and write about them in our journals. So, in direct proportion to the inharmonious action of these various classes will the strength of homœopathy be impaired, and the individual faith divided and weakened. A work becomes scientific not alone in proportion to the number of truths and facts which it contains, but in proportion to the proper classification and methodical arrangement of these truths and facts, so as to bring them within the possibility of attainment by those who study it. I believe our teachers are more or less unconsciously influenced by the almost universal tendency of our authors to adopt the more convenient alphabetical classification. They begin with A, and end with Z, and throw in all they can of that which goes between. To-day, perhaps, the instruction is given upon *abrotanum* with its disturbed digestion, great emaciation, and marasmus. To-morrow it may be *aconite,* with its active fever, thirst and restlessness. The next day the windy and exhaustive diarrhea of *aloe.* And then the dropsy of *apis,* and the bruises of *arnica,* and so on down the list, and all through the college course. It is readily seen, and has been experienced by many of us, that it would require a memory with superhuman power properly to grasp, separate, and hold these facts for scientific application at the bedside. All of the knowledge imparted in this way may be and probably is of pure gold, but it is tainted, nevertheless, with an unscientific color, because it lacks the methodical arrangement which brings it within the possibility of complete attainment by anyone. Would it not add greatly to the practical value and the scientific influence of our pharmacopeia if the drugs were classified according to their known therapeutic value? And then set apart 50, 75 or 100 drugs, which have been most thoroughly proved and tried, and found to be of first importancec to the homœo-

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pathic practitioner? Scientific research could proceed just the same. And this class of remedies revised every decade, if necessary. This would, officially, set apart a definite work for our various medical colleges, and our students would all study the same remedies and our uniform efforts would be put forth in the direction of greatest importance.

Now let us consider the single drug. What, of the vast accumulation of scientific knowledge of each individual drug, should be taught in our homœopathic colleges? Should we confine ourselves wholly to the study and teaching of symptomatology and potentization of drugs, in order to be good, true and faithful homœopaths? Should the homœopathic doctor refrain from the use of *morphine* and other palliative treatment in order to be patriotic and loyal to the banner under which he sails? Should a good, wide-awake, up-to-date, aggressive and progressive homœopathic physician be satisfied with anything less than all of the scientific knowledge of drugs? Is there anything that the old-school physician knows about drugs that the homœopathic physician has not a perfect right to know? Is there anything that pertains to the great field of medical learning that is not his by tradition, by inheritance and by right? Then what knowledge of drugs shall we, as homœopathic physicians, laudably ambitious to be the best in the field, impart to our students? I answer, All we know that is scientific and worthy of any physician's attention. And with it, a good, pure, methodically arranged, clean-cut homœopathy. Nothing less will fully satisfy, in this scientific age, the fertile and active mind of the young, ambitious doctor. It is my practice to begin here, as we should in all cases of scientific investigation, as near the bottom of the study as possible. Lay the foundation strong and well if you expect the superstructure to withstand the blasts of storm, time and criticism. We should teach the student something about the crude material from which our medicines are made, their nature and their classification, their habitat, and a short description of each article, as well as a brief history of the medicine, the part which is used for making the drug, how the drug is made, its power, and how to make its dilutions or triturations. We should also teach the range of physiological dose, as well as to give a definite understanding of the recommended potency, or medication. All the drug knowledge imparted to the student should be definitely classified, in a clear-cut and scientific manner. Placing a limit somewhere, not beyond the 30th decimal potency, for the material medication, and a limit from that point to some other definite point for the "spirit-like" medication. Then, in a concise, and yet sufficiently comprehensive manner, the student should be taught the physiological action of the material medicine, and in a separate classification the proving of the "spirit-like" medicine. In connection with this I would give, definitely and specifically, the time and cause of aggravation, the time and

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cause of amelioration, and the mental condition produced by the drug. I think it would be well to wind up with a brief and rational treatment for the poisonous effects of the material medicines, and the antidotes for the "spirit-like" medicines.

Third. Where Shall We Stop? Or, is there no stopping-place? Shall we continue to run until we are tired, exhausted and discouraged, because we can see no resting-place, or a possibility of mastering our science? And in this condition pull up to the delusive oasis of the allopathic camp for rest and refreshment? To our symptom-gathering there seems to be no end. We have placed before us impossibilities, with the impression conveyed to the student that we have mastered them, and that he also should be capable of mastering them. We have been deluded with the idea that each drug has the power to produce, or cause, from one to three thousand symptoms, all of which must be memorized to complete our knowledge of said drug. When the fact of the matter is, that the vast majority of these symptoms are either imaginary or secondary, and not in any sense true, scientific drug-symptoms. I believe that we have, in a large degree, actually sacrificed the real truth and worth of homœopathy for a delusion. This delusion is a great mass of imaginary and secondary symptoms on the one hand, and the extreme, unlimited triturating and diluting our medicines on the other. If we can get from six to a dozen well-marked, characteristic, primary symptoms of a drug, whether it be from the material action or "spirit-like" force, you may depend upon it that the individuality of that drug is well established, and that its curative power is all that can be expected within the domain of internal medication. I would give a hundred times more for a prescription based upon these logical, scientific possibilities, than I would for one where the mentality must, necessarily, be spread, in a less compact and concentrated form, over from one to three thousand symptoms, and the drug diluted to the ten-billionth part of nothingness, both of which are illogical impossibilities, and therefore not scientific.

I do not doubt that there is some soothing and healing virtue even in this manner of prescribing, but it belongs to another realm, and not to scientific medicine. It may be Christian science, or faith-healing, or hypnotic treatment, or Dowieism, or something of that sort. But whatever it may be, I feel quite sure that we cannot twist or warp or attenuate our therapeutic law to meet all these fads, nor to cover the scientific demands of both heaven and earth. The law is based upon material things. It is reasoned out through a material brain, and is applied to a material body. We accept the "spirit-like" force in drugs, because it is reasonable and logically scientific, and here is where we should stop. Even this should have its defined limitation somewhere within the bounds of reason's capabilities. There is a point at which the drug drops its material action

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and takes on the "spirit-like" force. When this is reached, allowing certain liberal bounds, it seems to me that it cannot be improved or made more "spirit-like." And this should be our stopping-place.

With these limitations our efforts will be more concentrated, our system of medicine more effectual, more scientific and more influential.

DISCUSSION:

A. C. COWPERTHWAITE, M. D.: To me the method in which Dr. Aurand has attempted to study this subject is distinctly an original one, and highly scientific in character, and I believe he has brought out some points in a way in which they have never been treated before. It is a most excellent paper, and I am glad to say a few words in regard to it. In the list of questions forwarded to those who were to discuss his paper Dr. Aurand asks, "Is the homœopathic materia medica based upon scientific law?" Has it come to the point that this question has to be answered in this day and age of the world? I should answer it most emphatically, "*Yes.*" If not, why are we here? If the homœopathic materia medica is not based upon a scientific law, what have we been doing the past century in upholding the law of *Similia* and the cause of homœopathy?

Question: Can this law be limited, and can it be more scientifically applied? There are times, of course, and occasions, perhaps, when a scientific law may be limited, not in itself, but in its application, and yet I can hardly conceive but that a law that is a natural law must always obtain under like conditions at all times, or else it is not a natural law, and is not a scientific law. But we must take into consideration our own finiteness, our own weakness, our own inability to be able to apply that law as it should be applied. Therefore, there are limitations, but the limitations are within ourselves, and not within the law. Can it be more scientifically applied? To my mind there is but one method of applying the law of similars. If the law is scientific, its application must be scientific, in so far as we follow that law. If, in our weakness, we fail in the application of that law, that might not be scientific, but the administration of the homœopathic remedy according to the homœopathic indication, must, and always must, be the same, and depends entirely upon our own individual capabilities strictly to follow the law of cure.

Should we begin our materia medica instruction by expounding the law? Most certainly! I think if there is any failure that our colleges meet with in the advancement of homœopathy, in the instruction of homœopathic principles, it is that they do not begin at the very beginning; do not put the study of materia medica in the senior year; do not put it in the junior year. Just as soon as the student enters the homœopathic college he should be told why he is there, why he is not in an allopathic college rather than a homœopathic college; what homœopathy is; upon what it is based; of what it consists, and not let him go along two or three years wondering why he is there, in distinction from being an old-school student. The law of homœopathy ought to be taught in every homœopathic college, first, last and all the time. I am sorry to say there is not enough of it.

Is our homœopathic materia medica, as it is to-day, a scientific book?

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That depends! I should want some one, perfectly capable of so doing, to tell me exactly, as near as possible (we have had one or two illustrations in Dr. Aurand's paper) what is science? That which was considered science ten, twenty or thirty years ago is now relegated to oblivion, and a new science has taken its place. The followers of the science of the present day claim that will remain science so long as the world endures. Yet, there are young men and young women to-day, I suppose, who will live to see many of the scientific theories of to-day exploded. And so, I do not know exactly what to say regarding this question, "Is our homœopathic materia medica to-day a scientific book?" Much of it undoubtedly is. That it has been encumbered by much that is useless, much that was not placed there in the manner that it should have been, goes without saying. That the methods, the opportunities, of a hundred years ago in preparing a pathogenesis of a drug, in studying of drug effects, etc., is not what it would be to-day, and I suppose our materia medica is somewhat lame in that it does not give us all the pathological effects of a drug according to the various sorts of measurements that we have at the present time, and which have been denominated as scientific in their character; but in so far as that materia medica has been verified over and over again, in so far as its provings have been repeatedly demonstrated, and what we know of that drug is the result of a century's experience, and not of a week or two, or a year or two, I should say that the homœopathic materia medica is to-day a scientific book.

"Does our materia medica seem complete, and is it possible to fully comprehend and understand it?" Now, what does that mean? Does it mean that we should fully comprehend and understand every symptom that is laid down in Allen's Encyclopedia? If so, while it may be very complete, we cannot understand it, and no doubt there are many conditions, many symptoms, many statements made in our materia medica that are beyond our comprehension in an ordinary way. At the same time I think it is safe to say that taking our materia medica as it stands, we comprehend it as fully as we can comprehend other scientific works of a like character.

"Should the material and spirit-like forces be taught in separate classification?" No; that which may be material to one may seem dynamic to another. It is not necessary, because it is material, that it should be physiological or mechanical in its character, nor can you tell what is spirit-like in force and material in force. The greatest cures ever performed have been with potencies far beyond material, and yet similar cures have been wrought with material forces, and I do not see how it is possible to make a separate classification, nor do I think this would tend to remove friction or odium. I, therefore, would answer this question in the negative.

Frank Kraft, M. D.: I allowed Dr. Cowperthwaite to have my notes, and he has spoken my speech. I had written my discussion, as I am quite an excellent speaker in my library when I have books around me. The questions are very graphically stated, and go right to the point. I will try and answer them in three minutes. It is very evident that Dr. Aurand is a teacher, as he has given me six questions on which I could hardly make forty per cent in the examination. The first question is,

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"What is your opinion of the paper in general?" These questions are put in that epigrammatic style for which the doctor is noted; they go right to the point, and ask a very striking leading question. The paper is, however, excellent in every way; I think it covers every point Hahnemann ever thought of, it is full of method, full of statements worthy to be thoroughly sifted and studied. The second question, "Which of the six hundred drugs contained in our pharmacopœia should be selected to form the groundwork of our materia medica instruction?" If I have one fad, it is not to have six hundred remedies. I don't believe you can carry fifty under your hat. When I was inducted into college work I offered to write seventy lectures. I wrote forty-five, and with forty-five I have instructed several hundred students, and occasionally a man or woman pops up and says, "That lecture on *lachesis* I have never forgotten." If I had given the students two hundred remedies, they would have forgotten everything. I think it is important to impress this upon the student's mind, that there are a few well-proved, thoroughly proved remedies, and valuable to take along at two o'clock in the morning. *Third.*—"Is it important that the various medical colleges of this country be uniformly engaged in teaching the same set of drugs at the same time?" I see no value in that whatever. Every man teaches according to his own ideas; he has his own pet remedies which he thinks will cure everything—*bryonia*, for instance—and it would be impossible for other professors to see *bryonia* as I see it. I think every professor should be left free to teach what remedies he likes, and the professor must also be a practitioner. If he is not a practitioner, his teaching is worth nothing; you can't teach unless you know, and you do not know from books.

Fourth.—"Would you recommend that scientific classification take preference over alphabetical convenience in our pharmacopœia and materia medica text-books?" In order to answer this question I will state it this way: When my time came to lecture (I am not lecturing now), I would take a series of remedies that applied to some prevailing disorder. When I began to lecture we were troubled with cholera; I selected five cholera remedies, and kept at those for a week, and some of the men here to-day reminded me of my lecture on *cuprum*, that thy had never forgotten. I adopt the plan of Dr. Dewey, of taking a remedy through and through, and talking it, chalking on the board, until it is heard and seen, and cannot be lost. I am not a believer in notebooks; we lose them and forget them; but if you take five points from every remedy, and make sure you understand them, they will be with you when you need them. Hence, I have taken *aconite*, usually to begin with, not because it is at the beginning of the homœopathic alphabet, but because *aconite* is a wonderful remedy in almost every case to which a practitioner is liable to be called. Of course, it does not fit every case, but it is a good one to know. Then I proceed to the other remedies, sometimes taking *sulphur* for the next. *Sulphur* is a wonderful remedy. Fourth, then, I don't believe in the scientific alphabetical classification. I fit the lecture to the times, and make it as impressive as I can.

Fifth.—"Is concentration of thought, uniformity of effort, and harmonious action one of the chief factors in lending strength to an institution or societies?" Undoubtedly! The question answers itself.

Sixth.—"Would it not add greatly to the practical value of the

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scientific influence of our pharmacopœia if the drugs were classified according to their known therapeutic value, and fifty, seventy-five or one hundred drugs be set apart as of first importance to our homœopathic practitioner, and recommend that these be uniformly taught in our various medical colleges?" I have already answered that. As I grow older I have fewer remedies. My memory is getting feeble. I can only carry thirty now, sometimes forty, and at the most fifty. When I left school I carried two hundred and fifty—in my note-book.

D. H. Beckwith, M. D.: I congratulate the essayist for his many suggestions and the ingenious method that he has presented for the reformation of the materia medica.

I believe, with the author, that the medical student should have a knowledge of drugs as taught by the allopathic and eclectic colleges. The student of materia medica in the homœopathic colleges should have a knowledge of drugs, and their action; it is his right by inheritance. If the student is well versed in the materia medica of other schools, he becomes a more liberal and scientific practitioner of medicine. By the knowledge thus obtained he is better prepared to study the "symptomen codex" and will make a true and better homœopathic practitioner; which statement is verified by the practitioners of homœopathy of half a century ago.

I again congratulate the author for shrewdness in his selection of two of the best materia medica teachers in the Institute to answer fifteen questions that he has assigned to them for their opinions. The answers they have just given the Institute will be read with profit to teachers and students of to-day, as well as in the future. Why the author makes his third selection is beyond my comprehension, unless it was to obtain a practical opinion of one who has administered "potentized" medicines for more than fifty years, and of one that listened to the teaching of drug-action in three different schools of medicine.

I will now attempt to answer some of the author's questions that he has assigned to me relative to his paper.

(1.) "Is the vast number of symptoms attached to each drug scientific, or confusing?" They are both scientific and confusing. The number of symptoms that are recorded of the polychrest remedies are scientific, for they have been proven by men of the Old World, and their statements have been confirmed by such men as we know, namely, Hering, Williamson, Dake and others, who were practitioners, and men that were educated, scientific and honest in their work.

The exact statement of these provers of facts that already existed makes a rational science.

If the symptomatology be studied in a rational manner, the sypmtoms recorded should not be confusing; because the student of to-day does not accept those vague and visionary symptoms that are recorded on the pages of the materia medica.

To the superficial student they are confusing.

(2.) "Is it true that each drug can and does produce the great number of symptoms which the records show?"

It is not in my province to say that the symptoms recorded by a prover do not produce what he has recorded. In this audience prob-

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ably no one believes in the doctrines taught by Christian scientists; yet we should not say their doctrines are false; because some of the most intelligent people in this city firmly believe in their truth, and substantiate their belief, in the Christian life they live, as well as by building the finest churches in Cleveland.

I believe some doctors are so constituted that they believe all, or nearly all, the recorded symptoms of each drug. Therefore I cannot answer the question.

(3.) "Is it true that a majority of these symptoms are either secondary or imaginary?"

The author must think I have a superhuman knowledge to expect an answer to his query. If he had desired my opinion I should answer that I believe many symptoms that are recorded by provers are entirely imaginary ones. My assertion neither proves or disproves; it is simply the opinion of one man; what seems to me a mere delusion may to others seem a reality.

(4.) "Have we not sacrificed much of the real truth and worth of homœopathy for the delusion of secondary and imaginary symptoms, and the extreme potentization of medicine?"

Many of the symptoms recorded are, in my opinion, unreliable; the liberal, progressive physician of to-day cannot accept them as true; therefore they are rejected by the student and practitioner. No doubt the cause of homœopathy has been retarded by publishing of symptoms that cannot be comprehended by many of our students.

As to the potentization of drugs, I am not prepared to say that we have "sacrificed through potentizations any worth of homœopathy." There are men in this Institute who are firm believers in high dilutions, men that are good and successful practitioners.

(5.) "Would you recommend that a definite limit be placed upon the potentization of material medicine, and in a separate class, a definite limit be placed upon the spirit-like medicines?"

I would recommend that every physician place the limit of potentization which in his own judgment would accomplish the best results for his patients. A limit cannot be placed to the potentization of "material medicine," therefore it should not be "placed in a separate class."

(6.) "For scientific purposes where do you think the 'spirit-like force' in a drug stops, or does it ever stop?"

An atom is defined "as one of the indivisible parts of which all nature is formed." Some philosophers have defined an atom as an "image floated from the mind." When an atom ceases to exist, then, and not till then, the *dynamic* force in medicine will cease. The effect of remedial agents on the human organism, not ascribable to either mechanical or chemical in the medicine, must be attributed to a dynamic force. Therefore, we cannot tell when the force of a drug ceases to exist.

I do not approve of the term the author uses as "spirit-like medicine," a "spirit-like force." No one knows when the force of a drug ceases to act.

(8.) "Do you think that present conditions have a tendency to drive homœopathic students and practitioners into allopathic colleges?"

I do not. This is an age of change in the medical, religious, and political world. Ministers seek other denominations for pecuniary rea-

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sons, the prospect of a larger congregation, or for some doctrines or creed that they are not in harmony with. Politicians are not rewarded by their party by positions in office which the ward worker thinks he is entitled to, and he leaves his party. Students may think that some schools are better equipped, have better instructors, and they select that college. Inducements are often presented to the medical student financially that will induce a change.

Some medical students desire to graduate in a school where different theories are taught, that they may become familiar with more than one system of medicine.

Some preceptors, who have resigned from homœopathic colleges, send their students to other institutions. The above conditions, to my own personal knowledge, have sent students to old-school colleges.

Some reputable physicians have left our school of medicine because they could not obtain a position in college work which they desired; therefore they organized a crusade against their *alma mater* and secured followers by their "missionary work."

Other practitioners have made the change because it would, as they thought, be more lucrative. Others because inducements were held out to them to better their financial and literary work. Others because they preferred two diplomas, believing that a knowledge of both systems of medicine would make them better or more popular physicians, and give them a prestige in town or country where located.

I do not believe the conditions of our materia medica have any tendency to drive sudents or practitioners into allopathic colleges.

C. B. Gilbert, M. D.: There are two or three points in the paper I shall discuss, the rest of the ground has been so thoroughly covered. In reference to the statement which the doctor made in regard to *sepia* and *pulsatilla*. He asks, Will *sepia* lift a retroverted womb; will *pulsatilla* produce version of a fetus? Now, if *sepia* will lift a retroverted womb sometimes, it certainly will keep it there after it has been replaced; but it is simply absurd to say that a mechanical condition can be cured by a remedy. The only thing a remedy can do is to correct the systemic condition which permits these displacements to occur. But if the forces of nature, under the directions of any drug, can do the work it is a great folly to undertake to do it mechanically. The real point at issue in these cases is the condition of the system, and if this is neglected, and you put a crutch under the womb, and fail to give the indicated remedy, the woman is just as badly off as before. So it is with *pulsatilla;* if *pulsatilla* will correct a malposition, it is not only folly, but dangerous, to undertake to accomplish the same thing by mechanical means. In my experience *pulsatilla* has corrected malpositions. The thing to do, however, is not to prescribe *pulsatilla* because you find a malposition, but to examine the case and prescribe *pulsatilla* if it is a *pulsatilla* case. According to the law, why should not *pulsatilla* effect a cure? The physician who gives *pulsatilla* simply because the child is in a wrong position is foolish; but if given as it should be, and the malposition is corrected, who shall say that *pulsatilla* has not aided Nature in her work?

W. J. Hawkes, M. D.: I will occupy the floor but a very few minutes. What I have to say is chiefly in the line of the remarks of the

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last speaker in regard to the statement in the paper about *pulsatilla* and *sepia*. It showed to my mind that the author of the paper did not have a clear conception of what the function of medicine consists. It is perfectly absurd to say that *pulsatilla* turned a child *in utero*, or that *sepia* raised a prolapsed uterus. When, however, the child is not in a normal position, and the uterus is out of place, there is something wrong. The natural position of the child is the left occipito-iliac-anterior, and the natural position of the uterus is with the fundus pitched a little forward; and when not in these positions, nature is out of tune. Now the function of medicine is to put nature right; to remove the stumbling-blocks from her pathway. When this is done, nature, herself, lifts that uterus into position and corrects the position of the child. Nature is always working with her greatest ability to have things right, and medicine is only given to assist her. Medicine works on the nervous system entirely, and one knows but little of medicine who does not know this. You have a wrong idea of medicine if you think medicine cures; it simply enables nature to do her work. Nature in health, plus drugs, is no stronger, if so strong, as nature without them.

About the study of materia medica: it is impossible for any human brain to carry the whole materia medica; but it is possible to carry four or five characteristics of each of the larger portion of the remedies. It is said that Napoleon knew every one of his soldiers. He knew the peculiar features of each one and could call each by name. These men all had features in common; you have all got ears and eyes, noses, mouths, etc., but each one has his own individual characteristics, which distinguish him from all the others. No two of the two thousand million peopling the earth have precisely the same features, but each one has two or three or four individual marks. This is true of drugs, and it is familiarity with these distinguishing peculiarities which constitutes a working knowledge of materia medica; but it requires hard work to acquire that knowledge on the part of the student.

Much has been said about allopathic drugs. There are no allopathic drugs; and as to a knowledge of drugs, what business has anyone to know more about them than the homœopathic physician? The very essence of "the science of therapeutics"—homœopathy—is a thorough knowledge of the action of drugs, both pathogenic and therapeutic. In regard to the progress of medicine in the old school, what is it? Is it some new hypnotic? A new coal-tar preparation? We want to know all about them; we do know all about them. We want to know all about them for the same reason the man wanted to know the location of the bandits—he wanted to know so as to avoid them.

H. C. Allen, M. D.: I want to explain the misapprehension of terms. The system of Hahnemann differs from all other systems ever promulgated in this particular: It is dynamic from beginning to end; all others are based on mechanics. Now, the author of the paper to-day asks two or three somewhat important questions, but I think if he would go to the bottom of the questions thoroughly, experimentally, he would answer them himself; they are very easily answered. For instance, I think we should not use in our scientific discussions the terms "dilutions" and "triturations." We do not dilute a remedy to increase its

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force; we potentize it. Use the term "potency" and see how much better it is; "potency" means power, force, strength, and when you have a potentized remedy you have a strong remedy, not a weak one. Why? Because it fits Dr. Hahnemann's theory of disease, which is that a derangement of the vital force is a disease. The author of the paper says "run up a remedy to the ten-millionth part of nothing." Why, you cannot destroy matter! What are you talking about? It is out of the question altogether. We never need depart from Hahnemann's method if we only follow Hahnemann's method in applying it. But you cannot practice homœopathy on the allopathic basis of finding a remedy for a disease irrespective of the totality of symptoms.

S. H. Aurand, M. D.: Mr Chairman—I want to thank the gentlemen who have discussed my paper for their kind and lenient treatment. I expected more and harsher criticism than I have received. I can assure you that the paper was written in all sincerity and honesty, but I think that I did not make myself quite fully understood on some points. Let me say one thing in a general way, however, before I take up the special points in their order. Have you noticed all the way through the discussion of my paper how the speakers have differed in their general understanding of the points at issue, our materia medica in general as a science, and of the specific action of our remedies? This is conclusive evidence, to me at least, that confusion exists somewhere, and that if I have not the correct understanding of medicine, I am consoled with the fact that there are others also who have not.

As to the limitation of the law, and to the separate proving of the material and "spirit-like" medicine I do not think that I am quite understood. We are seeking for practical truths more than anything else. We all know that in our general practice we meet cases many times where we find it necessary, right and just to resort to the use of material medicine, and we also know that on the other hand the extremely high potencies are recommended and are said in some instances to have made some very marvellous, if not miraculous cures. And it was in this connection that I simply referred to quinine, blue mass, sepia and pulsatilla. Now the question which I wish to get at is this, Does our law cover all of these extremes; can we depend upon its accuracy and power to guide when we prescribe the crude material, and likewise when we prescribe the seven-millionth potency? In other words, are we willing to concede to the faddist's idea that it is by the operation of this law, from a medical standpoint, that the psychologist cures his cases, the Christian scientist and the suggestive-therapeutist cure theirs? Or, should we limit the law of *similia* to scientific medicine, and thereby give to all other therapeutic methods due credit for all the truth they possess.

Now, the other point which I tried to make is this: Our symptoms are a confused mass because they are taken from the action of the tincture, and also from the highly potentized medicine. We do not know how to prescribe our medicines, whether in low or high potency; we are not positive as to the power of our higher potencies, and some of us are very skeptical indeed. Now, if we could prove the high potencies separately, and record only such symptoms as they are capable of producing, we might in this way obtain definite knowledge of their therapeutic value.

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Dr. Kraft thinks that we do not understand remedies alike; he does not expect other men to understand bryonia as he understands it. I think it is a very poor science that cannot give us all a like definite understanding of the therapeutic value of bryonia. If our system is scientific, I must be led to prescribe bryonia by the same set of symptoms which leads Dr. Kraft to prescribe it. If I prescribe bryonia, and prescribe it accurately, all other men who wish to prescribe it scientifically must understand it as I do.

Dr. Hawkes thinks that I do not have quite a correct understanding of the action of medicine because I stated that pulsatilla was used to correct the position of the child *in utero*. This does not need argument, for I am well aware of the fact that there is much yet for me to learn. But this statement was simply made in passing, to show the extremes for which medicines are recommended. However, I wish to say that Dr. Hawkes was my teacher and taught me not all that I know, but a good deal. I wish further to frankly state, not to the detriment of Dr. Hawkes, because I always loved him, and love him now; he is an excellent teacher and an honest man, but when I graduated I did not know all about drugs, and there were few, if any, of the class that did. We did not know all that the allopaths know about drugs. He did not teach us anything about the physiological action and dosage of the tinctures. We were taught nothing but symptomatology, pure and simple, from beginning to end. This custom, I am sorry to say, is followed too much by too many of our homœopathic colleges. I was not long in finding out that my knowledge of drugs was entirely too meagre for an all-round, full-fledged doctor. I determined to know more, and therefore did what a great many others have done, viz., took a course in an allopathic college, which not alone supplied my want of drug knowledge, but it made me a more confirmed and ardent homœopath. We as homœopaths have a right to know all there is to be known of drugs. Our homœopathic institutions should teach all the scientific knowledge of drugs, from the tincture to the highest dilutions and triturations.

I feel very grateful to you, gentlemen, for the kindly way in which you have received this paper. I wanted to bring out the very points which this discussion has elicited, and I hope no one has been injured.

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SOME PRACTICAL OBSERVATIONS ON THE STRENGTH OF MEDICINES

W. A. Dewey, M. D.
ANN ARBOR

This is practically my first offense of writing on the question of potency. I did once read a paper, which was never published, before a local society on the question and, therefore, I feel at liberty to include in the present paper some of the points of that one. I wish to state at the offset that I am not a high-potency man, a low-potency man, or a no-potency man, but I am one of the class that believes in and uses all potencies. The subject of potency is one that is generally tabooed by our societies, as provocative of perhaps too acrimonious discussion. It has been presented to our societies in all its phases, some advocating the high, some the low, and some that secure middle ground between the two, while a few have arrived at a solution of the question, namely, by individualizing in potency with as much care as is done in the selection of the remedy.

The question of dose is certainly one of the most serious points of our therapeutics. After the recognition of the disease comes the choice of the remedy, but after the choice of the remedy comes the choice of the dose. The dogma of indivualization extends as much to the dose as it does to the choice of the remedy.

My object in presenting this paper is not to go into the subject of potencies exhaustively, but simply to give a few points that partake wholly of personal experience and observation during nearly a quarter of a century's work in the medical field. I believe that by comparing our experiences we can derive much value and, perhaps, secure better results in our treatment of disease. There reigns relative to dose in our school an incertitude amounting to almost anarchy. If some light can be thrown on the question by our discussion, and some accumulated evidence can be obtained, some good will be accomplished.

The allopathic school have what is called a system of dosage; that is, each remedy has indicated for it a minimum and a maximum dose, and the range between these is very extensive, so much so, that practically this school is as much at sea, as far as absolute dosage goes, as we are.

We often hear it stated that dose has nothing to do with homœopathy; that if a cure is wrought, it is a homœopathic one, no matter what the dose. I am not prepared to accept this as a correct statement, for I believe that Nature does some curing, and that some cases recover in

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spite of the homœopathic medication; I further believe that cases are spoiled by giving the wrong homœopathic medicine, and I mean by this that recovery is retarded thereby, and that the same occurs when an unsuitable potency is given.

What the suitable potency is, is the question to be decided. It can only be answered by experience and experiment, and it will be a long time before it can be determined with scientific accuracy.

Again, we hear it said that certain drugs act better in certain potencies, some in the higher and some in the lower. This, in a measure, is a correct statement, but it is by no means absolute. There is one point of which I am certain, namely, that any remedy, no matter what it is, must be given in a sub-physiological dose in order to effect the best homœopathic cure. It must be given in a less dose than was used to prove it upon the healthy. In other words, I believe that if a remedy was proved in the third potency and its pathogenesis is wholly obtained from that potency, it should be given in potencies higher than the third, in order to get its *best* homœopathic action in disease. I do not mean by this that lower potencies will not act, or that cures will not be made by the lower ones, but that *better* results and *quicker* cures will be had from those potencies which are higher.

In passing, I would say that when high potencies are mentioned in this essay, I do not mean the potencies of Swan, Jenichen, Fincke and other makers who follow simply a bottle-washing process, but the genuine Hahnemannian potencies, not going perhaps above the 200th or the 1,000th. The former are not what they are claimed to be, often, in fact, being lower than the 12th Hahnemannian potency, though labeled way up in the millions. Hahnemann used the 30th, and never went higher except for experimental purposes. I believe that much injury has been done by thse chimerical potencies, which are not what they are supposed to represent.

On the other hand, I also believe that perhaps as great an injury has been done to Homœopathy by giving our remedies in doses that are sometimes fully as strong, and in some instances stronger, than the regular allopathic dose would be. It is the dynamic effect that the homœopathic physician should seek, not the materialistic one; yet it should be remembered that "dynamics" mean power, and that matter is force.

Permit me now to specialize a few remedies.

Pulsatilla.

This is a remedy that was proven especially in the lower potencies, and most of its symptomatology is derived from the administration of the drug in strengths above the tincture. It has been my experience with this remedy that it acts best in the 6th potency and upwards. I have yet to see the decided action of *Pulsatilla* in the tincture and lower po-

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tencies that I have seen in the higher. Dr. Jousset, in his *Practice of Medicine,* recommends this remedy in the tincture, in some catarrhal conditions, and in the 6th and 30th; in others, for instance, he recommends it low in coryza, and in the 6th in measles; in the tincture in gonorrhœa, and in the 6th in leucorrhœa. In chlorosis the 6th seems the most effective.

Chamomilla.

The above remarks apply equally well to *Chamomilla.* I have often heard physicians remark that they seldom, if ever, prescribed *Chamomilla;* that it had never come up to their expectations, and that *Ferrum phosphoricum* was nearly always a substitute therefor. If these same physicians would use *Chamomilla* in the 12th potency, or at least not lower than the sixth, their respect for it would return. Dr. Bayes and Dr. Madden, of England, used this potency, and Jousset does not mention its use in strengths below the third.

Gelsemium.

This is a remedy that I formerly used in the lowest potencies, and in California, where I practiced for a number of years, it was seldom, owing to climatic conditions, that Aconite was indicated. Gelsemium was our Aconite. I have seen excellent results from Gelsemium in the tincture and extreme low potencies that I have never been able to obtain in the higher, and I have tried it quite faithfully in the higher potencies. In paralytic conditions, however, it seems as if it ought to act best in the higher potencies, but I have not seen evidence of it. In nervous headache and migraine there is no better potency than the 30th c.

Aconite.

That there are certain conditions where a remedy may act well in low potencies, yet in other conditions it acts better when given high, I am fully aware, and this might be illustrated with *Aconite.* In very acute affections the remedy should be given as low as the third. In neuralgias, however, I have found Aconite 30th a very satisfying potency. This condition obtains with every remedy. It has been said, the healthier an organism is the lower a medicine it takes to disarrange it, but when the system is already disarranged, and the more it is disarranged, the higher the potency necessary to make an impression. This being true, and the *Aconite* condition being a rugged one, it would seem that *Aconite* high would be the logical strength. It has always been my experience that it does act better in potencies above those that would produce physiological effects.

Bryonia.

This is a remedy that I use almost exclusively in the 3rd potency. Formerly I gave it in the tincture and first dilution, but I have never had the prompt results in the lower dilutions that I have had in the third.

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Another thing that I have observed about *Bryonia* is that it should not be repeated too often. I believe it a mistake to give *Bryonia* every half-hour; better effects will be had if the remedy be given every three or four hours, even in the most acute cases. In rheumatic affections, only, might *Bryonia* be used lower, though even here Dr. Bayes recommends the 18th dilution. Dr. Dahlke, of Berlin, asserts the higher potencies will do all that can be expected of the remedy.

Graphites.

In gastric complaints I have found this remedy most active in the 12th potency; this is the one recommended by Dr. Jousset, from whom I got the idea, and I have found it to work well in this strength.

Nux Vomica.

This is another remedy Dr. Jousset recommends in the 12th potency in gastric disorders, especially when accompanied by constipation, and this too I have verified. I have seen *Nux vomica* 200 cure constipation when the lower potencies, 3rd, 12th and 30th, have failed. I am positive that we have no better potency than the 200th in a genuine *Nux vomica* constipation.

Anacardium.

This remedy is similar to *Nux* in many ways, and in my hands it has been practically useless in potencies lower than the 12th, and I have heard this fact emphasized by a number of physicians. In mental troubles some authorities speak favorably of the lower potencies.

Cannabis Sativa.

In the treatment of gonorrhea I have never had such gratifying results from *Cannabis sativa* in the tincture as I have had from the third potency. In an extensive practice in this affection I formerly gave ten-drop doses of the tincture, but soon found that a less dose was more efficacious, and have been led to believe that those who have had no results, or unsatisfactory ones, with *Cannabis sativa* have given it too low.

Coffea.

The 30th potency of this remedy in sleeplessness, according to my experience, is the only potency to give. By this I mean that I have never been able to get satisfactory results with the lower potencies. This may be due to the fact that, inasmuch as coffee is an almost universal beverage, high potencies act better.

Digitalis.

This is a remedy that I never give in any other potency than the third. If it be indicated homœopathically by its slow pulse, its sinking at the epigastrium, and its other well-known symptoms, it will act well in this strength. I do not give it for a rapid pulse homœopathically, for it is never indicated.

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Conium.

If I am positive of any one thing in medicine it is the power of *Conium* 30th to cure certain "lumps" in the female breast. It has been my experience repeatedly to see tumors of a suspicious nature in the mammæ disappear by the use of *Conium* in this potency. Of course the indications must present themselves here, as with any other remedy. There are piercing pains, a tender gland, with a fugitive stitching here and there in it. More especially is it indicated if the lump dates from some injury, such as a blow. I do not know but other potencies would do the same, but I am sure of the 30th, and could relate a number of cases wherein it has prevented the advised use of the surgeon's knife. If we wait too long, or if the case is one too far advanced, time may be lost, to the detriment of the patient. Of this I am aware, but in most cases in the early stages of mammary tumors the waiting of a few weeks will not result in harm to the patient if the case be watched. It is in the formative stage of these neoplasms that the remedy will act by checking the development of the growth.

Arsenicum.

This is a remedy said to bear potentiation better than any other in the materia medica, and I believe that it is the universal testimony that the third centesimal potency is as low as it should be used. I think one can tie to this potency with considerable security. In intermittents, however, and in neuralgias, the higher potencies act better, and apparently it matters not how high one goes.

Sanguinaria.

In headache this remedy has served me best in the tincture, but some authorities prefer the 6th. In rheumatism the higher potencies have proved more satisfactory to me.

Lycopodium.

This remedy is usually advised in the high potencies, along with other so-called inert drugs, and it is in the higher potencies that it will work in the majority of cases, yet I have seen *Lycopodium* in the tincture do most satisfactory work in the so-called uric-acid diathesis, in clearing up the red-sand deposit in the urine when potencies had failed. The homœopathicity of this is apparent.

Veratrum Viride.

This I have never used in any strength but the tincture; I would like to hear of its use in other potencies, but so few cases correspond to it homœopathically that I have had little opportunity to test it.

Kali Muriaticum.

One of the positive things in medicine is the power of *Kali muriaticum* to cure the ordinary follicular sore throat that occurs in children as a result of dietary indiscretion. I have so often verified this that I

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am sure of its action. I use the 6th, having tried the 3rd and the 12th with less satisfactory results. The white-coated tongue should be present.

Capsicum.

This is a remedy that will be found useful in the third potency in dysentery and in ear-troubles, but in the gastric troubles from alcoholic excesses, give the tincture.

Veratrum Album.

This is a remedy that I am actually afraid of in potencies below the 6th in diarrheas; not that it does not work, for it does work, and that too promptly. I have seen patients with choleraic diarrhea die from the too sudden stoppage of the discharge, from the administration of *Veratrum* 60th. The higher potencies act less promptly and with less danger.

Psorinum.

The efficacy of high potencies, the 30th or the 200th, preferably the latter, may be well tested by *Psorinum*. It is a wonderful remedy, and one not to be despised when well chosen.

Ignatia.

Perhaps more failures are made with this remedy because of the use of lower potencies than any other. The higher potencies act best.

Phosphoric Acid.

In the 12th potency I have seen *Phosphoric acid* check the night-sweats of phthisis, giving the patient increased strength during the action of this remedy.

Carbo Vegetabilis.

This is most always recommended and used in the higher potencies, but the 6th will act well in indigestion with acid or acrid eructations, and the other symptoms of the remedy present.

Cinchona.

There is no doubt but that too many physicians err in giving *Cinchona* too low in symptomatic anemia; this was well pointed out by Dr. George Royal. He advocates the 30th, and I have seen it work well.

Belladonna.

While the medium potencies of this remedy are to be preferred in most cases, in all hyperesthetic conditions of the brain with intensified and violent symptoms the higher potencies should be given.

It would, perhaps, be possible to extend this paper to an unlimited extent by calling up other remedies; it has, perhaps, become tiresome already. There is one point, however, that I wish to mention; it is this:

Students oftentimes become possessed of the idea that the stronger the dose the quicker the cure. I recall my student days and the wonder and admiration Dr. Austin Flint excited when he wrote one of his interminable prescriptions upon the blackboard; the longer and stronger they

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were the more the applause. An error in those who are beginning to practice homœopathy is that medicine must have a taste and color to satisfy the patient. This has worked great injury to the cause of homœopathy, for the allopaths have accused us of giving stronger doses than they do. It has ever been an endeavor of the allopathic school to disguise and render pleasant their doses, yet there are homœopaths who habitually give *Bryonia, Nux Vomica* and *Colocynth* in the bitterest of doses, the acids so that they burn, *Iodine* and *Cinchona* in the darkest of liquids, even using coloring-matters simply to satisfy their patients, when better results would be obtained and the patient would be as well satisfied by the tasteless preparations.

Finally, it has ever been my opinion that the adoption of the decimal scale as a dispensing one has been a mistake, and has worked injury to the cause of homœopathy by furnishing preparations that oftentimes too nearly approach, in fact and in application, those of allopathy. I am aware that finer and better division is obtained; but this could be obtained by changing the mode of procedure in making the centesimal potencies.

We should never lose sight of that fundamental principle of homœopathy, namely, to give the least possible amount of medicine that will cure.

DISCUSSION:

C. E. WALTON, M. D.: Mr. Chairman —I have practiced medicine nearly thirty years, and I thought I had become immune to surprise, but the greatest surprise of my life was when a short time ago I received this paper of Dr. Dewey, with, not the request, but a command to discuss it. I do not like to arraign any man's motives, but the only reason I can suggest for having this command made on me is that at last he had found one who would not disagree with him in anything, or possibly, in my blundering way, if he had produced a paper which no one could controvert, I would say something that would excite discussion on your part.

In discussing a paper on this subject we must make a sharp distinction between dose and potency. It may be somewhat elemental to speak of this here, but I am sure that there is a very careless use of these terms. The paper speaks of the allopath defining his dose, and the homœopath defining his. What is the difference? The allopathic distinction of dose is made upon the basis of minimum and maximum safety of quantity. The homeopathic dose is the difference between the physiological and the dynamic dose. Dosage refers to quantity; potency refers to quality. The allopathic physician who says he gives ten grains of *quinine* clearly states what he uses, but the homœopathic physician when he says he gives a dose of *cinchona*, leaves us to guess what potency he uses, for we are usually unable to tell what potency he prescribed, and that is what we wish to know—what quality, not what quantity. So there is the sharp distinction we as homœopaths should always make between dose and potency. Like Dr. Dewey, I am a pan-potency man. I give low and I

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give high and I give medium. Why do I make the distinction? Because I find different things to be done and the choice of a potency depends upon what you have to do and the length of time in which you have to do it. If you were a farmer and had to take stumps out of a field to get crops in speedily, you would apply dynamite to those stumps, blow them up and clear off your ground. If you had plenty of time, you might pour coal oil on the stumps, and the next spring set fire to them and let them burn down gradually and clear up the ground in that way. The same is true in medicine; sometimes you want to blow up your patients with dynamite, and you do not have time to wait. Then you choose that potency which you think will do it. I do not always know which one to choose. It is a question, the doctor says, of experience. The subject of potency is not mixed up with a theory. We have passed theories. Here is our sick man. What has experience taught us to give this person? It is for this purpose that this paper was written; to accumulate, if possible, the experience of the practitioner in determining potency. Now, how are we to accomplish it? One very important thing should be done by every one who writes for a journal: Whenever you say you give *bryonia*, say what potency; not necessarily how many times, nor how often, but what *potency*. It makes a good deal of difference whether you give *bryonia* in the first potency and set the patient's head to cracking, or give the thirtieth potency and do no good, or give the sixth potency and finally cure the patient. That is what we want to know.

I have had experience in various potencies with different remedies. I do not care to run through a long list, as Dr. Dewey did, but I will mention a few remedies. There is one thing he said which I do not believe, and I am glad of it; he said that remedies should always be given in a sub-physiological dose in order to make a cure. If you have a man who has been thrown out of the buggy and his head thrown against a post are you going to stand and fiddle with the thirtieth potency? No; give ten drops of tincture of *aconite* and that will wake him up if anything will. It is the similimum to shock. *Aloes* I have used high for chronic diarrhea, so many times, that I never go to an *aloes* case of diarrhea without giving *aloes* in the thirtieth potency. But let me tell you here about a case, a beautiful *aloes* case; I gave *aloes* in the thirtieth potency and it did no good. I took the case again, was satisfied it presented a perfect picture of *aloes*, and prescribed it in the twentieth, with similar failure. I then went to the tenth, then the sixth, and finally down to the first, when the patient got well. Now then, some of you say, the thirtieth is just getting in its work; you do not want to wait so long; if given the first at the start he would have improved much more rapidly.

CHARLES MOHR, M. D.: I rise to commend very highly this paper of Dr. Dewey on the ground that it is thoroughly Hahnemannian so far as dose is concerned. Those of us who have studied the history of Hahnemann know that he placed a limitation on the potency at the thirtieth centesimal dilution. He experimented, as the author has said, with higher potencies, but very infrequently. After coming to the conclusion that the thirtieth centesimal dilution was the limit to which potentization might be carried, he practiced with very much lower preparations, showing that he himself had no law as to dose, but followed the rule to give that dose which produced a remedial effect without giving rise, if pos-

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sible to avoid it, to any subsequent drug-effect. In the Organon he refers to drug aggravation, and shows that even when a drug is given in a potency, in a dilution, attenuation or trituration, as some prefer to call the preparations, it happens that owing to certain susceptibilities not known before the medicine was administered, drug aggravation does arise. Then, of course, there is nothing to do except to stop the medicine, or follow it with another that will correct the vital disturbances that have been created by a dose too large for that individual patient. Now, Mr. Chairman, there is one thing I think we should all consider: I believe we are dosing our patients entirely too much even in the homœopathic school of practice. I believe that when you give a dose of medicine, whether that potency be the first decimal, the thirtieth centesimal, or higher, the moment you have secured a remedial effect the drug should be discontinued, and the remedy be allowed to act until it has expended its curative effects.

There is one thing in Dr. Dewey's paper deserving of criticism. He thinks it was a mistake for the homœopathic school to have adopted the decimal system of preparation and notation. Now, I do not. In the first place, the decimal system, I believe (if history is correct), originated with Hering, and I have heard Hering say with his own lips that it was with Hahnemann's approval. As the custom of giving decimal doses is so universal at the present time I believe it would be a mistake to go back and employ the centesimal system alone. There may be some advantage in the decimal system in enabling practitioners to employ the intermediate potencies like 3x, 5x, 7x, etc. Furthermore, if, as some of us believe, the succussion which our preparations receive *potentises* the drug. making it stronger or more dynamic, then the decimal preparations should be stronger than the centesimal, because they have received more shakes or more succussion. Thus the first centesimal and the second decimal are equal in *quantity* of drug in menstruum, but in *quality* they may differ, as the latter preparation has received one more series of shakes than the former.

H. C. Allen, M. D.: I want to make a suggestion and ask a question. Why is it we can not arrive at some law of dose; of some rule of action by which we may know what dose to give, what potency to use? I do not think the case illustrated by Dr. Walton of any value, where he began with the 30th, then the 20th, the 15th, the 12th, the 6th and finally the first; why not begin with the first, and cure the patient there and then?

The question of susceptibility controls the dose; and should control the potency. How shall we arrive at that? Simply by knowing something about our patients. Some patients are extremely susceptible to some remedies or some potencies of some remedies, and we should know enough about them to find out. In early life the infant is extremely susceptible to medication; in old age the patient is extremely susceptible to potency. We should beware of giving a strong potency to an aged patient or to a baby. Some of you perhaps may have seen this illustrated in patients who are susceptible to the poison of *rhus;* in a damp day its poison aroma is exuded a long distance from the plant. Persons who are extremely susceptible to the action of *rhus* may be poisoned

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a hundred feet away from the plant simply by inhaling. Others may not be affected by handling it. What is the difference? Susceptibility. What makes susceptibility? The psoric, syphilitic or tubercular diathesis of the patient. Such a patient is already overloaded, over-weighted, by an internal miasm, a dyscrasia that is reducing the vitality of the patient and rendering him susceptible to external influences. Here is where dosage comes in. The susceptibility of the patient based upon the miasmatic condition of the patient.

J. B. G. Custis, M. D.: Mr. Chairman:—I was in hopes that Dr. Dewey could settle this question for us, because we have to look to men connected with Universities to settle these questions. The busy doctor must always get results. He is not required to tell how or why. In fact, he has not the time that he wishes for study or explanations.

Dr. Allen's remarks are a surprise to me. I do not believe that the question of potency has anything to do with inherent susceptibility. We all by custom and habit sometimes use a high potency and sometimes a low potency in the treatment of disease, and in writing papers, or discussing papers written by others, think of our experience with but one remedy. I consider that one of the most dangerous teachings of our professors of materia medica that the potency should be decided by the apparent severity of the case and the natural susceptibility of the patient. I would make it depend upon the vitality of the patient at the time of the prescription; the vitality of a patient varies according to circumstances. If it did not, we would all contract contagious diseases whenever exposed, or would run the gamut of them all because of constant exposure. I use most of the potencies, and, for example, would mention *nux vomica*. The patient who has been up all night still has some of the liquor imbibed in his stomach; or if he has mince-pie or walnut-cake as an offending substance in his stomach he will respond to a lower potency of *nux vomica*, which will give the desired results, but his vitality has not been necessarily lowered. In time he would have thrown off the offending material and recovered without assistance. Still, on the other hand, if he continues to tax nature by a repetition of the same debauchery his vitality will be lowered and the reflex and constitutional symptoms, many of which proceed from the stomach, will be relieved more rapidly and permanently by *nux vomica* given in a higher potency.

W. A. Dewey, M. D. (Essayist): I have nothing particular to say, Mr. Chairman, since those who discussed the paper have dealt so kindly with me, except on one remark by the one who lead in the discussion of the paper where he criticised the use of the term "dose," instead of "potency." I guess I had better not say anything about that, inasmuch as the Doctor who discussed the paper said himself that whenever you write an article for the journals always put the "dose" in. That covers the whole subject.

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THE SIGNIFICANCE OF SYMPTOMS

WILSON A. SMITH, M. D.
MORGAN PARK, ILL.

If you should ask a man interested in internal medicine what he liked to study the best of all in medicine, there is no doubt in my mind but what the answer would be *symptoms*. And if he would like to study symptoms, he certainly is desirous of learning something of their significance. The ability to correctly understand the language of symptoms makes the selection of the internal remedy a much easier task and a more successful one than a blind matching of symptoms.

Some years since, at the meeting of the American Institute at the city of Washington, in 1892, the writer of this paper presented one on the subject of "Diagnosis and Drugs," in which the statement was made that the more significant of a disease a symptom present in a case, the less its value in the selection of a remedy. This statement has been reiterated by most of the teachers of materia medica since that time, and often before, but, like the old story of love, it will bear repeating. It is safe to emphasize the assertion that not every symptom signifies a remedy.

To obtain a clearer insight into this, let me take some of the symptoms of a disease; that is, symptoms that of themselves are diagnostic of certain diseased conditions, like rheumatism. A pain in the knee does not mean any remedy to the materia medicist. It indicates the need of a remedy, but the remedy lies in the background, upon just such a symptom. A pain in the knee, accompanied with fever, swelling of the joint, great pain and distress upon moving the same, with uric acid present in the urine to an excess, signifies no remedy yet. This set of symptoms is diagnositic of rheumatism. These two sets of symptoms, the pain in the knee and the others which have just been mentioned are, first, symptoms of location, second, symptoms of diagnosis, but still are far from being exactly the symptoms the one is looking for who wishes to prescribe the internal remedy.

Let us go farther, and state: The patient is restless, that gentle motion relieves, that aggravation comes after midnight, better from warmth, and there is present an unquenchable thirst, and every tyro in medicine knows, or at least ought to know, the last symptoms signify, and only signify, *rhus toxicodendron.*

Take the first set of symptoms mentioned again; add to them the following: Extremely sensitive to touch; pain of a burning, stinging,

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sore character; thirstlessness, swelling of the joints, pale, puffy, and you have, what? First, your symptoms of location, pain in the knee; second, your symptoms of diagnosis, fever, swollen joint, aggravation on motion, uric acid in the system, and third, your therapeutic symptoms signifying that this is a case for *apis mellifica.*

To study the meaning of symptoms, then, they should be divided into three distinct heads. *First,* symptoms of location; *second,* symptoms of diagnosis, and, *third,* therapeutic symptoms. When we so divide these symptoms we get a better and an easier understanding of the study of internal medicine. Just to illustrate this point, take pruritus ani; this is often a local symptom, and indicates some derangement of that part of the animal economy; but, unfortunately, it often appears as reflex symptom, and, when it is reflex, its value for the indication of a remedy is greater than when it is diagnostic of the disease. Thus, we often find pruritus present in women suffering from ovaritis. When such is the case, the remedy having pruritus as a symptom, and also having in its pathogenesis an affinity for the ovaries, becomes the remedy par excellence, the only volunteer needed to fight the battle. Pruritus ani is sometimes a concomitant symptom of enlarged prostate gland. When such is the case the remedy which possesses the urinary symptoms found in the case of hypertrophied prostate, *plus* the itching of the anus, becomes the curative remedy always, and without a single exception to the rule.

In both these instances the pruritus is but a reflex symptom. One might inquire if reflex symptoms are valuable. Yes, always; but only valuable as we understand their source and grasp their significance. When we learn from whence they arise, they become of great worth, for they either tell us what is the cause of the disease, or what is the remedy. It has been a misunderstanding of the significance that has led good men to suggest the use of *cina* in hydrocephalus, for all the symptoms of the brain by *cina* are reflex from intestinal irritation, and not from its peculiar effect upon the brain; hence, there can be no brain lesion present when *cina* is curative.

This dividing symptom in these three classes brings one to the point of asserting that the claims of those physicians who announce that their prescriptions are based upon the totality of symptoms are unwarranted by the facts. The truth of the matter is that all successful prescriptions are based upon the peculiar, or unusual symptoms, present in a case. Is not this correct? Take the rheumatic case just presented, does the pain in the knee indicate any single remedy or combination of remedies? Would you be willing to write for your pharmacist a prescription based upon that symptom of locality alone? Then add the ones designated as "diagnostic," "fever, swelling of the joint, great pain on moving, uric

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acid in excess," and would you still feel satisfied with a prescription based upon these symptoms? No, a hundred times, no! You would want the peculiar symptoms, whether better or worse from motion, from heat or cold, you would want the presence or absence of thirst, and these would be the ones upon which you base your prescription, and these are the ones which would cure.

I truly believe that every physician in the land would be a homœopathic physician today had it not been for the fact that we have misled them as well as ourselves, in their search for that remedy which possesses all the symptoms present in a case, rather than to have taught them, as we should, that the curative remedy is the one covering the peculiar symptoms.

What symptoms call for the remedy in typhoid fever? Is it Widal's test? Is it pain and tenderness in the ileo-cecal region? Is it the step-ladder rise of temperature during the first week? Is it the fact that the patient has diarrhea? Is it the presence of tympanites? Not a single one of these symptoms mentioned signify the internal administration of a single remedy. It is the peculiar symptoms which lead you aright. The restlessness which brings to your mind *rhus toxicodendron* or *arsenic,* the thirstlessness which calls up *apis* and *pulsatilla,* the aggravation at night of *mercurius* and *rhus,* which peculiar symptoms stand out as beacon-lights in a therapeutic sea.

Then, the significance of some symptoms are always plain and clear. Like the scriptural injunction, they are "without variableness or shadow of turning." The vertigo of *conium* caused by turning, whether in bed or anywhere, is one of the golden grains in our therapeutic warehouse, and always signifies *conium.* The adherent stool which indicates *aluminum* no matter what the microscope may tell us or the test-tube reveal; the white-coated tongue calling for *antimonium crudum* is as unchanging in its significance as the needle in the mariner's compass; the tearful, changeable patient, better out-of-doors, is a *pulsatilla* girl, with all due respect to the laboratory report of the blood-count.

My only object in presenting this short paper upon this topic is the hope that it may be the means of strengthening the weakening bonds of some of those who are looking towards the old school with longing eyes. If we would take the patience to study the significance of symptoms we would not be led into the habit of alternation, nor the use of combination tablets.

I believe in laboratory work; I believe in the use of the miscroscope, the test-tube, the Widal method of making a diagnosis, the blood-count; in fact, all the modern methods of studying pathology. But when that is done I still pin my faith to the method of cure which has stood the test for over a century, and which now has grown so strong as to be

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threatened with destruction by the swallowing process of those who "love us but to destroy."

When the germ of vertigo is found, the germ of the emotions is captured, and all those which go to explain why some persons laugh and others cry, why one patient with a fever will have diarrhea and another constipation, why the Klebs-Lœffler bacilli in one case will produce what we term diphtheria, and in others remain harmless; when that time comes, count on finding me with a test-tube under my nose and throwing the peculiar symptomatology of the homœopathic school out of the window.

In the cases of cholera which are now being treated by our scientific brethren of the "regular" school in Manila, P. I., the death-rate has been something near eighty-three per cent. and I defy any single man, or a multitude of men, to ever find any such a death-rate under the poorest homœopathic skill ever exhibited in any country. Until a better showing is made by the dominant school, I must confess that I would far rather risk my life in the hands of a competent homœopath than under the care of the most ultra-scientific physician of the dominant school.

The significance of symptoms then, is simply, *Study your materia medica.*

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HOMŒOPATHY IN THE HOMŒOPATHIC COLLEGE

WM. BOERICKE, M. D.
SAN FRANCISCO

At first thought, it must seem that the subject is so self-evident that any consideration of it must be superfluous. For where else than in a homœopathic college can a systematic knowledge of homœopathy be obtained; and again, no matter what else, certainly homœopathy must be taught in a homœopathic college. That it should have become a subject proving that a real or imagined divorce has either taken place or is for consideration at all shows that in some minds a question has arisen, threatened between these two parties—the *college* and *homœopathy*. Assuming the correctness of this assertion, I asked myself what are the chief causes at work favoring the development of this state of things? I answer:

First: The phenomenal development of extra-homœopathic therapeutics, surgical, mechanical, dietetic, anti-toxic, balneologic, electric, various forms of light and heat, *etc.* Many of these forms of non-homœopathic therapeutics are able to meet the demand of patients not only for palliation, but often for permanent cure. Chief among them, of course, stands modern surgery, whose wonderful development in our generation has put into the hands of the physician powers undreamed of in the time of Hahnemann, and greatly narrowed the sphere of his activity in the treatment of chronic diseases. Its marvelous technique and perfect asepsis yield concrete results at the behest of the operator, which so allure us all, especially the young student, and in a degree makes the study of materia medica less attractive. Again, preventive medicine and its corollary, that of a more correct knowledge of etiology of acute diseases, based upon a study of bacteriology, has led to the study of *diseases* rather than that of *patients;* more to the fascinating study of medicine as a science rather than to the more prosaic pursuit of taking care of the individual patients, which is the distinctive field of homœopathy. Then there is this other very important factor. While surgery clears the ground of pathological entities, of results of diseases, thus occupying a field practically beyond the reach of internal medication in its present state, and one wholly different, therefore, from that occupied by the physician, the hitherto unquestioned sphere of homœopathic treatment received a rude shock by still further limitation of its field. This was the study of the natural history of diseases by which the self-limitation and orderly evolution of many acute diseases

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has been established. We of a later and more critical generation can see that some if not many of the reputed and reported cures of earlier homœopathy must at least divide the honors with this self-limitation of many acute diseases.

Now, if we remember the powerful influence upon the young mind of tangible, concrete results sought and obtained by surgery, and compare these with what must appear as elusive, often delusive, vital changes that are the objects of medicine administered for its dynamic properties, we can see how difficult is the formation of a mind readily receptive of homœopathy. Compare again the *kind* of aid modern surgery requires from medicine, and see how it differs from that which homœopathy can give. She demands drugs that can *coerce* vital processes according to its behests and temporary needs, and hence she has greater use for the direct, physiological non-homœopathic drug-action, the sedative opium, the relaxing chloroform, the stimulating strychnine, *etc.* These are her medicinal aids by natural right; they express certainties of drug-action largely independent of the individual peculiarities of the patient akin to the mechanical directness of surgery itself, and therefore the natural allies of surgery.

Besides these *external* causes of the weakening of homœopathic sway in certain quarters, there is also a cause from *within* the school itself very largely responsible for our lack of virility, and it is especially the younger element that suffers from it. I refer to the neglect of the study of the principles of homœopathy—mere superficial application of the facts of materia medica and therapeutics, with neglect of the study of the underlying philosophy of homœopathy. Without this they run dangerously near to becoming empirical facts only, liable to displacement by some more favored new-comer, exactly as we see it daily in the old school, where a Ringer or an Aulde transfers from our own Hughes and other writers remedies that to us are perennially true and useful, because with us connected with the corresponding principles governing their selection, but to *them* without such knowledge, they become mere clinical suggestions and fads of the hour. Such superficial and very common homœopathic practice not only leads to frequent disappointment, but what is far more important, *it fails to reveal the real powers and extent of homœopathy as a system of therapeutics.*

These, to my mind, are the causes that are shaping the teaching of homœopathy, and that have made the modern homœopathic physician something different from his brother of a generation ago. They have sobered our conception of the supposed universality of homœopathy. They are in reality wholesome correctives of untenable claims. I believe instead of weakening the sway of homœopathy they have merely helped to define our boundary line, and within our own legitimate domain

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homœopathy *is* and ever will be the science of therapeutics—of medicinal dynamic therapeutics. Now what is the duty of the College with these facts in view? By recognizing the wide field of general therapeutics and the many avenues open to the physician of influencing, directly or indirectly, for better or for worse, cellular vitality, avail ourselves of these if we choose and dare to present homœopathy as one department only in the great field of therapeutics; the commanding, the crowning department, if you please, but dare to teach that *there are others.* Show up their inferiority, their limitations, their unreasonableness, their dangers, but dare to give them place. Rightful recognition of other therapeutic methods in no way lessens the sphere of homœopathy. It precisionizes it. Rendering unto Cæsar the things that are Cæsar's does not imply giving up higher things. It merely discriminates, while it exalts the nobler. The truly helpful teacher of materia medica, for instance, should teach, aye, *must* teach from his homœopathic rostrum, that besides the application of the homœopathic principle to drug-action, universal in its adaptability, there is a direct drug-action by means of a definite dosage that is *not* homœopathic, yet capable in a limited way of very definite and precise and certain service—a service becoming less necessary as homœopathy progresses, yet a service of which every physician must avail himself at times. The fearless acceptance of these teachings, the proper placing of these facts in the therapeutic resources of the physician as palliatives, and to bridge over sudden acute and dangerous conditions, will do more to strengthen homœopathy in the mind of the student and preserve our self-respect as honest men, than all else.

Second: The College must take the lead in presenting homœopathy, like any other natural science, as a series of independent doctrines, as a philosophy. I deem it more important that the student should be thoroughly grounded in the *underlying principles* than in acquiring a stock of key-note symptoms, important and essential as this is.

In order that our discipleship may culminate in something positive and unmistakable, let me indicate one or two directions where, in future, the teacher of homœopathy must lay special stress if he will do justice to the latent possibilities of our method. First of all, the College must keep alive the source and perpetuate the method of its knowledge of drug-action by establishing and maintaining a college of drug provings. This has ever been and will continue to be the only living fountain of materia medica, and will alone preserve to homœopathy leadership in the study of drug-action. This is the crying need and duty of the hour. Again, the college must teach more fully the essential facts of Hahnemann's doctrine of chronic diseases. Not a perfunctory literal statement of his three miasms, but the truth of the fact of suppression, of

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the skin-phase of many chronic diseases, the importance of the patient's individuality over and above mere diagnostic symptoms of his disease, *as guide to the curative remedy;* the importance of pre-natal constitutional and eradicative treatment by means chiefly of so-called anti-psoric remedies. It is along these lines that our distinctive work lies, where we have no competitors, and where success means permanent improvement of the race.

Every member of the faculty must be imbued with this faith if you want to implant it in our students. Does he occupy, for instance, the surgical chair? Let him be ever so deft with his knife, ever so skillful in his palliative measures; while he clears the periphery of the organism of the tangible *results* of disease, he fails to dignify the chair in a homœopathic college unless he supplements the surgical work by appropriate eradicative medicinal treatment aimed at the diathesis and constitutional peculiarities of the patient while his surgery takes care of the structural lesion.

Or, does he occupy the chair of physiology? Even this has a direct relation to homœopathy. He cannot afford to ignore Hahnemann's teachings in regard to the vital force, although he may bring more modern interpretative light on the subject, but he fails to dignify his chair from a homœopathic point of view if he is blind to the reaction that is taking place in the scientific world against the former mechanical physiological views. The new vitalist school of physiologists is very much in the line of Hahnemann's views.

Such faithful teaching of homœopathy from every chair in the college is the present need of the school. I speak for the greatest liberality and individual freedom, but every teacher and practitioner of homœopathy is required, *first* of all to do that which loyalty to homœopathy calls for. With us it is not the question of what is *permitted to do, but what is first required by our discipleship as homoeopathists.* This does not exclude the use of any measure or method, but places it where it belongs, and in the proper rank. Such teaching will soon be felt by the student, and you will raise up a generation of strong, intelligent men with convictions and a rational understanding of what is truly distinctive in the school. More than that, it will result in an unconscious education of an equally intelligent and loyal laity, a homœopathic sentiment and community, now sadly lacking, and the presence of which will enable us to do so much more in the future than in the past. Given such firm and loyal homœopathic laymen, and we are enabled to appeal successfully to them to give us aid in securing our rightful representation in public and private institutions, in army and navy, and thus give homœopathy the needed opportunity to prove its superiority over every other method of therapeutics.

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THE TWO COHOSHES

By Frank Kraft, M. D.
CLEVELAND

The Blue and the Black. Caulophyllum and Cimicifuga. Rheumatism and Uterus. Man and Woman.

When I have a general similarity of the two cohoshes I think of caulophyllum in rheumatism, and, hence, in men's diseases; and of cimicifuga in uterine troubles, and, hence, in women's diseases.

This is not to say that cimicifuga may not be used for men, or caulophyllum for women. It merely says that for a quick distinction, in order to have a range-finder, I have, after a number of years of confusion and trouble, arbitrarily separated the two cohoshes in this way. (I am speaking now to general practitioners, and am not lecturing to a class of undergraduates.)

If you will carefully study the two cohoshes, as you did at college, if not since, you will see running through them a general similarity. You have found that the head-symptoms of the one cohosh are so much like those of the other cohosh, that, like the old woman's test of good lye, the spoon will float—or sink—she wan't quite certain—that you are perplexed to know which of the cohoshes is which, and which isn't.

This is one of the greatest difficulties of our materia medica—this frequent and unhappy general similarity in allied departments of the human body. After spending some time tracing out in caulophyllum, let us say, the headache, you feel confident that now you have that headache anchored high and dry beyond all peradventure of doubt; and yet, on a following occasion, when you take up the study of cimicifuga you are amazed at the similarity in general lines.

Take that most excellent little brochure, *Bell's Diarrhœa,* and note how the same general peculiarities of bowel disease appear in the great majority of the remedies. If you study bryonia for a while until you thoroughly understand that peculiar autumnal diarrhœa, and then turn colchicum or colocynth, or other allied remedies, you can find your same autumnal diarrhœa with a mere shade of difference. The same is true of rheumatism, of typhoid fever, of coughs, of sleep, of sleeplessness, of urinary and uterine difficulties—in fact, as we old hands know, it runs through all individual departments of the therapeutic list—a stubborn fact which all the more emphasizes the rule, if I may not, in a loud voice, call it a law—that as homœopaths we must not deal with disease-names, or disease-entities, but with the whole man or woman.

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All are but parts of one stupendous whole,
Whose body Nature is, and God the soul.

My use of the two cohoshes has become very much of the nature of empiricism, based, of course, on a long and patient study of the two remedies from a homœopathic standpoint. But after a run of years of general practice, unconsciously the homœopathic remedies have ranged themselves in groups and classes, and if one is not ultra careful and a constant student, he will find himself driving along in ruts and grooves from which it will be most difficult to extricate himself.

If I touch a case of rheumatism, I find myself instinctively questioning my patient along the line of a half-dozen rheumatic remedies; fitting my patient to my Procrustean bed, rather than fitting the metaphorical couch to the patient.

No one knows better than myself that this is not homœopathic prescribing; but unless one is constantly engaged in study, or teaching a class of students, who look up to him from the depths of their praiseworthy innocence, and take everything that falls from his lips as and for gospel truth, and strive faithfully to give back the exact words in quiz, the general physician will find himself straying after the bread-and-butter essentials, and very much inclined to leave the fine-spun theories and philosophies with the medical college professors, who, in order to vary the monotony of the century-old materia medica, will oft-times strive after odd symptoms, odd statements, odd results, picked up here and there in their reading, but not in their practice.

For a long while after I left my dear alma mater I thought only of cimicifuga for the ante-parturient state. I had been taught that this remedy given in the 200th, a few disks each morning in the seventh month, would work that most wonderful of wonders, the strengthening of the circular fibers of the uterus, and thus shorten the hours of actual labor—just as pulsatilla, given a few hours preceding the hour of supreme travail, would secure and insure a proper presentation, and as well assist in strengthening the longitudinal fibers of that same uterus. I had the implicit faith of the Scriptures, which is capable of moving a mountain; but after laboring with that mountain in labor for a number of years, and no special advantage accruing from the promised remedial effects of cimicifuga, I fell away from the letter of the law and found myself straying in other pastures—to my homœopathic confusion be it told—but with good results.

Now, when I have a case of obstetrics in prospect, somewhere in the eighth month, I direct that the expectant mother provide herself with an ounce package of squaw-root—caulophyllum—the dry herb, and each morning, for a month, make for herself a cup of tea and drink as hot as

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bearable. Thus far this has helped me in my cases, though I could not prove it even "if Bill Jones was alive." My swans may all have been just ordinary geese, notwithstanding. But this I do know, that whereas under the former treatment with the 200ths, I had met with undesirable results and prolonged labors, now I have but little trouble even with primiparæ.

If I am in doubt as to the difference between the two cohoshes I apply my empirical rule of rheumatism and uterus—man and woman. For if I have the well-described rheumatism of the small joints I lean to caulophyllum for either sex; which general distinction, of course, fails me when I come to cimicifuga. There I have only the general conditions to save me from confusion and dismissal. Then I take up the head symptoms, and the sexual symptoms—for I find cimicifuga a most excellent remedy in the seminal emissions—and this I have taken from the Eclectics, giving it in 10 to 30 drops after meals. For sleeplessness in either sex I know of nothing at this writing which will equal cimicifuga —always adding, "if indicated," and it usually is in nervous, easily-excited, ill-nourished people, who have overdone in mental work—while caulophyllum devotes itself pretty much to the physical overdoing.

The classical symptoms of mental depression, "blueness" almost to distraction and suicide, so well described in the books as a cloud descending and enveloping the patient in cimicifuga, is a very real one, and most precious indication. It has always been associated in my mind with that sensation reported from the obstetric patient, where chloroform has been administered to the obstetrical degree and the woman says: "I see you, Doctor, I hear you, I know what you are doing; but you have put a curtain between me and my pains." Cimicifuga drops a curtain—a "pall," it is called—between the patient and her right-mindedness. She knows what she is doing, but she is powerless to help herself out of her cloud of disheartenment and trouble.

I have found cimicifuga a master-key to unlock the lumbar district when we have that troublesome lumbago of the parturient woman, and as well the unparturient man. But in the latter instance you will find some wrong in his sexual department as a primary source of his lumbago. In such cases I help out matters, in the male, with a cold compress to the lower part of the spine, and as men, as a rule, take most unkindly and profanely to cold water applied to the body, internally or externally, I always instruct the wife to see that it is properly applied. I am a little fearful of cold water to the parturient woman.

In the woman I find cimicfuga a sovereign remedy "worth a guinea a bottle" in rheumatism, unless some other remedy is clearly indicated. In cimicifuga I govern myself mainly by the cramping pains in the groins and back and legs, with the pall-like depression—and the general

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soreness and bruisedness—which latter might cause one to stray off into the arnica fields, except that cimicifuga lacks the foulness and blue and yellow color of arnica.

The book says that in cimicifuga there is soreness from overexertion, as in gymnastics, dancing, skating and the like. Unless, however, I have other distinct and clear-cut symptoms calling for this remedy, I turn most confidently to caulophyllum, because I have learned that cimicifuga is more likely to be of a lazy disposition physically, while caulophyllum is inclined to be active. In a general way I distinguish the two remedies in rheumatism by the cramping and twisting and squeezing pains of cimicifuga, and the general soreness in caulophyllum —the pains in the wrists and fingers, the ankles and toes, where they can't hold on to a cup or a pen, can't stand without turning the ankle. The latter, too, has a pulsatilla symptom, in that the pains fly from point to point. But caulophyllum is more often indicated in dark-complexioned people of intense irritability, tears being a rare commodity, and good nature at a large premium.

One other empirical use of calophyllum which has given me excellent satisfaction has been in thrush, that most troublesome complaint in mother and babe. I have found that 20 to 60 drops of a low dilution in a glass of warm water applied upon a swab to the visible sores will produce prompt amelioration, and I give it internally in doses of the 12th or 30th once every four or five hours. Those of you who have run the gamut from boracic acid to sage-tea and back to hydrozone and permanganate of potash will appreciate this little practical point.

I like caulophyllum much better than cimicifuga when abortion threatens. Of course in such danger I do not use the tea or the lower numbers. Then I employ the homœopathic attenuations and follow closely the homœopathic landmarks. For a time I was afraid to give the tea to the parturient woman, fearful of precipitating trouble. But I have used it now for a number of years and have had no accident. It is needless to add that I would not give this or any other possible abortifacient to a woman who has had former mishaps. I have discovered long before this time that there is a good deal in medicine beside medicine. And it is well to mix your medicines "with brains, Sir!"

In conclusion of my rambling remarks—for I have not attempted to lecture this audience on the differences between the two cohoshes, but only to point out a few special lines in one department for which both are used most often, I will say that I use caulophyllum for rheumatic troubles in either sex, as a range-finder; and cimicifuga when I have a general rheumatism in the gentler sex—meaning thereby God's last, best gift to man—woman.

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DISCUSSION:

S. H. AURAND, M. D.: First, I wish to say a few words about Dr. Kraft's "rangefinder," of his method of separating these two drugs. My method may not be as good as his, but it is quite different, and leads me to entirely different conclusions. I always try to picture a drug upon my mind in the same natural way that I would, almost unconsciously, adopt to remember a person, a horse or a tree, taking into consideration the most general, natural characteristics, as appearance, size, contour, disposition, strength, pleasing or displeasing qualities, affinity for the surroundings, and its value as a benefactor to the human race. Adopting this method I would contrast the blue and the black cohoshes as follows: They both belong to the highest botanical classification. "The blue" is characteristic of a soft, mild, gentle and yielding disposition, while the black is stern, decided, dark and gloomy. *Caulophyllum* belongs to the natural order *berberidaceae,* but *cimicifuga* associates itself with the *ranunculaceae* group. The tinctures are both made from the fresh root, and are one-tenth drug power. The milder, and, in my opinion, more womanly remedy, the blue cohosh, naturally has a greater affinity for water, while the more stern black cohosh, very masculine-like, will yield itself more freely to alcohol. Hence the second dilution of *caulophyllum* must be made with one part tincture, four parts distilled water and five parts strong alcohol; while *cimicifuga* works very harmoniously with one part tincture to nine parts of dispensing alcohol. I wish to say right here that very much depends upon how these remedies are prepared in order to retain a perfect solution, and therefore obtain the best therapeutic results. The tincture of the milder remedy, the blue cohosh, has a mild, sweetish-bitter taste, while the black, very characteristically, has a very harsh, astringent-bitter taste. The relationship of these two remedies to each other, I think, is very much like sister to brother. And the average individual can tolerate much more of the sister than of the brother. So the physiological dosage ranges itself accordingly. From 10 to 90 minims of the tincture of *caulophyllum* may be used without harm to the patient, while *cimicifuga* should be held within the bounds of 5 to 30 minims. Both of these herbs grow in the United States and Canada. The *caulophyllum* plant grows to the modest height of about two feet, and its name indicates that it is very much like one single rib of *cimicifuga.* It is taken from "*kaulos,*" a stem, and "*phyllon,*" a leaf, because the stem appears to be simply a leaf-stalk. *Cimicifuga* is more masculine in its appearance. It grows tall and strong, reaching a height of 5 to 8 feet, and bears the unpleasant cognomen of bug-chaser—"*cimex,*" a bug, and "*fugo,*" to drive away. These natural characteristics help very materially to individualize drugs, and can nearly always be made to serve as range-finders for their therapeutic application. According to the above, and also what shall follow, I should have to change Dr. Kraft's headlines and make them to read thus: "The Blue and the Black. Caulophyllum and Cimicifuga. Uterus and Rheumatism. Woman and Man."

Both of these remedies have three special centers of action, the two principal of which have been considered in Dr. Kraft's paper. I believe the uterus is the main field of action for *caulophyllum.* Here it acts as

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a motor stimulant and that produces hysterical hyperesthesia. Its properties are, therefore, emmenagogue and parturifacient, and this explains why Dr. Kraft's squaw-root tea was followed by such excellent results. I do not agree with him when he says that in doing this he fell away from the letter of the law and found himself straying in other pastures —to his homœopathic confusion. If confusion, or blundering, he may wish to call it, I want to say that in accordance with my opinions, he blundered directly into the homœopathic field, and conclusively proved it by the results he obtained. *Caulophyllum,* if used in sufficient strength, will be found to be an admirable remedy in a great many of the abnormal conditions of labor and the lying-in period. When the woman is excessively nervous and hysterical, and suffering with irregular, spasmodic pains, from debility of the excito-motor nerves of the uterus, *caulophyllum,* in material doses, has proved itself to be a most excellent remedy. I should like also to recommend its trial in other uterine difficulties, such as spasmodic dysmenorrhea, spasmodic after-pains, retained secundines, threatened abortion, amenorrhea with choreic spasms, hysterical or epileptiform spasms at puberty. My chief guiding symptom is, irregular, spasmodic pains, with great nervous excitement. I certainly believe that the pappoose-root does, as Dr. Kraft has said, tone up the debilitated uterus and prepare it for an easy delivery. The second important property of this drug is its power to produce and cure rheumatism of the small muscles and joints. And here I fully agree with Dr. Kraft, excepting that I give this property second place. *Caulophyllum* has a third center of action, which is not very prominent. Besides its two resins it contains a glucoside known as *saponin,* which accounts for its power to produce spasmodic affections of the chest and larynx.

I consider that *cimicifuga* is first and foremost a general rheumatic remedy, and therefore more adapted to the ailments of men than is *caulophyllum.* I think, however, that so far as sex is concerned I use this drug about equally. Its first action seems to be upon the cerebro-spinal nervous system, where it produces a rheumatic hyperesthesia, causing chorea and paralysis. This is in accordance with Dr. Burt's classification, and my experience with the drug leads me to believe it is right. It also has a marked action upon the circulation, producing irritability and a feeble and irregular heart. I classify *cimicifuga* as a very irritable and gloomy remedy, for it produces and cures just such symptoms. Its third special center of action is upon the sexual organs of either the male or female, and here it seems to have power over about the same kind of symptoms which it relieves in other parts of the body, those of rheumatism and neuralgia. The symptoms are more constant and general than those of caulophyllum, and yet they are somewhat spasmodic and changeable. There is much apparent similarity in the action of these two remedies upon the female generative system. But my experience leads me to believe that *cimicifuga* is especially adapted to those cases which are rheumatic or neuralgic in character, or where the ovario-uterine difficulty is the result of rheumatism in other parts of the body. But, on the other hand, *caulophyllum* acts well, in many cases of uterine debility with general debility, moth-spots on the face, etc., where there is no rheumatism at all. The

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characteristic headache of *caulophyllum,* I find, is mostly due to uterine difficulties, while that of *cimicifuga* has a rheumatic or neuralgic origin. The mental condition of *caulophyllum* is excitable, with general nervous excitement. While the *cimicifuga* patient is very irritable, melancholy, dejected and miserable. The *caulophyllum* symptoms are ameliorated in the morning, while the *cimicifuga* symptoms are aggravated in the morning.

No remedy in the materia medica has served me so well for the relief of lumbago, or "crick in the back," as has *cimicifuga.* And not many, perhaps, are better for the relief of irregular, spasmodic uterine difficulties, than *caulophyllum.* In conclusion, therefore, I will say, that as a "range-finder" I think of *cimicifuga* in general, or special, rheumatic difficulties in either sex, and of *caulophyllum* in the difficulties peculiar to women, with or without its peculiarly characteristic rheumatism.

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MATERIA MEDICA—A STUDY

J. C. FAHNESTOCK, M. D.
PIQUA, O.

"When the mind with great earnestness, and of choice, fixes its views on any idea, considers it on all sides, and will not be called off by the ordinary solicitations of other ideas, it is that we call intention, or study."

When the word *study* is used in this paper it will imply the mental effort of understanding, and an earnest and protected examination of the materia medica, by reflection, collection, and scrutiny of evidences obtainable.

By way of prelude it is well to repeat again the first, the most wonderful and magnificent truths of the philosophy of homœopathy, the foundation upon which our materia medica is constructed, without which there can exist no science of therapeutics.

First: "The body of man in health is animated by a spiritual, self-moving, vital power, which holds it in harmonious order."

Second: "The spirit-like power to alter man's state of health (and hence to cure disease) which lies hidden in the inner nature of medicines can never be discovered by us by mere effort of reason; it is only by experience of the phenomena it displays when acting in the state of health of man that we can become clearly cognizant of it."

To the earnest and true physician the study of materia medica is one of the most fascinating works that can be imagined. Its field is so broad and varied that any student can easily be satisfied, for it takes into account the boundless creation of God, with man as its chief concern.

Its importance can be fully realized when it is taken into consideration that when medicines are *properly* selected and applied, it precedes, accompanies, and follows every procedure used for the relief of suffering humanity.

A review of the study of materia medica is quite in keeping at the present time, as a wave of discontent has again swept over a few of the homœopathic ranks.

For this I am truly glad, for such a feeling is certain indication that the lesson has not been *thoroughly learned*, or properly applied—errors have crept in, or evidences are lacking.

In the reproving of the materia medica there cannot exist the least

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doubt in the minds of any of its great value in the thorough study of the inherent dynamic property of each drug in question, providing the rules laid down by Hahnemann are strictly followed.

The method presented by the founder of homœopathy stands today pre-eminently above all others. Every means known to man must be used to ascertain the entire sick-making properties of a drug, for it is then only that the exact fulfillment of his matchless methods are fully realized.

In Section 141, Hahnemann tells us the best way to study a remedy is for the physician to make a proving upon himself, providing he be healthy, sensitive, and has an unprejudiced mind.

"By such observations upon himself he will be brought to understand his own sensations, his mode of thinking and his disposition, (the foundation of all true wisdom), and he will also be trained to be what every physician ought to be, a good observer."

In the examination of the true sick-making powers of drugs, Hahnemann demands on the part of the physician an *unprejudiced mind,* sound understanding, attention, and fidelity in observing the images produced in all the drug trials.

An unprejudiced mind! Sound understanding, attention, and fidelity in observation! An unprejudiced mind is hard to find—the majority of us are full of prejudice and endless shades of belief. It is very evident that they are not all facts, but they come from what each one has laid down as facts. Each one desires to have peculiar ideas, facts, etc.

Here we see cropping out the worst kind of prejudice. A true man is certainly one freest from prejudices, and one who can observe evidences. The unprejudiced mind is the one to occupy the seat of judgment and make decisions.

An unprejudiced mind can only be attained by learning all the truths and doctrines of homœopathy.

If we study carefully that part of the Organon included in the Sections 118 to 145, we can learn how the materia medica was formed, and also its best methods of study.

In Section 118 it is clearly pointed out to us that each remedy must be treated as an individual, and that one individual can never be taken for another, which should ever put an end to substitution, alternation, or combinations. It should be clear enough to any of us when the founder of homœopathy said when speaking of the proving and study of drugs, "that everything conjectural, all that is mere assertion or imaginary, should be strictly excluded; everything should be the pure language of nature, *carefully* and *honestly interrogated.*"

Having a materia medica constructed upon the above principles,

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it can be readily noted by repeated provings that all the different phases of the drug are not brought out in one prover, but it takes many provers fully to note the entire sick-making powers.

This peculiar fact will teach the close observer that each one of us is living on a certain plane and in a certain atmosphere of his own.

Of the many methods employed in the study of the materia medica, from Hahnemann down to the present, there is one that surely takes the lead of them all; while at the same time any method which gives us aid must not be ignored.

The method to which I refer is the getting of the complete symptomatology of a drug, as the totality of the symptoms is the *ne plus ultra* in the homœopathic materia medica.

It will not take an observer very long to note that the symptoms can readily be arranged into different classes according to their importance and occurrence. These different classes of symptoms can best be divided into those that are general, those that are common, and those that are particular. These classes in turn are sub-divided into first, second and third grades according to their degree of importance or occurrence.

The general symptoms of any remedy stand first in importance. All symptoms that are predicated of the patient himself are general; all symptoms predicated of any one organ are particular.

Those symptoms which appeal closest to our very being, our vital force, are the things that are strictly general, but those symptoms which become less and less general are particular.

When the *ego* is brought into use the symptoms mostly are general; for example, when he says, "I *feel*," "I *do* so-and-so," "I *feel* so cold," or "I *feel* so hot," "I *am* thirsty," "I *am* wakeful," or the woman says, "I menstruate," referring to her general condition, and not to any special organ.

To illustrate: One of the general symptoms found in *apis* is a burning, stinging sensation. The patient says, "I have a burning, stinging sensation all over my body;" "I feel a neuralgiac pain in my temples, like a bee-sting;" "I have a burning, stinging in my eyes;" "I have a burning, stinging in my face;" "I have a burning, stinging along the edges of my tongue."

So these symptoms of *burning, stinging* pains are noted all through the remedy, and constitute the *general symptoms*. The generals are the ones which control the army of symptoms noted in *apis*, and in like manner all other remedies. The *generals* are the ones related to the patient himself, to his very being. And these very important symptoms are just the ones that so many want stricken out—"the

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would-be chaff," as they call them. What do you think would be left if these chaff-blowers could only have their way in this matter?

The *common* symptoms are those which anyone would naturally expect in a remedy. Take, for an example, remedies which produce fever. We naturally expect thirst, and thirst would be a common symptom.

I have heard it repeated so many times that such-and-such symptom can be found under a dozen different remedies, and they should be expunged from the books, they are all worthless.

The cavillers did not recognize the fact that these were all common symptoms, and belong there naturally, and that the symptomatology would not be complete without them.

Again, all remedies which produce eruptions are classed as a common symptom. What would we think of the symptom of dragging down in the pelvis? Why, it would be a common symptom, common to many remedies—but to study out the exact place of each one of them we must get the generals and possibly the particular, strange, or uncommon ones.

Now, as to the particular symptoms. They are the ones that cause one to pause and to meditate. You naturally would say to yourself, "this is strange;" "this is something peculiar indeed." Take in the case of *apis* again. The patient has a high fever, but does not drink. How strange that is! That would be a *peculiar* symptom, a *particular* symptom, or, as the students of materia medica would say, one of the *characteristic symptoms* of *apis*.

The general, common, or particular symptoms can be arranged according to degrees. In either class, those symptoms found the most frequently or constantly are of the first degree, those less frequently of a second degree, those occasionally of the third degree.

Now, if we diligently study all our remedies in the above manner we shall be able to get a very clear picture of all well-proven remedies. Then, to verify or prove them homœopathically by the correct application of them, we fasten those images so that they can be recalled when their use is required.

At this place in my paper I feel like the minister who attempted to make a speech before a large audience and his hearers were very anxious to hear another gentleman in his stead. When the minister arose the crowd began to hiss and shout, "Sit down!" He did not sit down, but raised both hands high in the air as if he were in the act of pronouncing the benediction, and said, "Keep quiet! I do not want to make a speech, but I want to tell you something."

I want to tell you that the materia medica is studied very little by the mass of homœopathic physicians of to-day. You can go into

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three-fourths of all offices of this fair land and not see a materia medica in sight, or, if it is, you could write your name on the covers.

Further, how many repertories will you see, and how many know how to use them? How many do you suppose have studied one remedy thoroughly this year? You know very well that many materia medicas are not opened once a week or once a month by the majority of physicians.

These are the men that want to use the pruning-hooks, and blow "chaff"—principally the latter.

In those offices you will find the combination-tablets, and if the dispenser happens to run out of them he will put two or three remedies in a glass, or give a half-dozen remedies in two days.

Then there goes up a great howl about the pharmacists selling all kinds of combinations. Why is it these pharmacies make these combinations? Simply because they have sale for them; a demand from their patrons. Who buys them? These men who never study their materia medica.

"When we have to do with an art whose end is the saving of life, any neglect to make ourselves thoroughly master of it becomes a crime." May the good Lord have mercy on the criminals of this country!

It is only constant effort that leads towards perfection in any calling in life.

Those of you who take part in the re-proving of drugs with unprejudiced minds and will look up all the original matter upon the drug in question, especially that of Hahnemann, will then learn to know the greatness of the man who formulated the law of *similia similibus curantur,* and that he was one of God's grandest noblemen.

DISCUSSION:

A. S. ROSENBERGER, M. D.: Dr. Fahnestock is quite right, and is to be commended for the high ground which he takes in regard to the materia medica.

To the homœpath it is of prime importance; his first resource in the large majority of his cases. Its importance, therefore, calls for a relative amount of study on the part of those who profess to adhere to the doctrines of homœopathy.

The writer's accusations of neglect of the study of the materia medica, and the principles of homœopathy, are not without foundation. The majority of the profession, no doubt, honestly designate their practice as homœopathic, and depend very largely upon the homœopathic materia medica, but they are too often found prescribing empirically, and are mere routinists. The use of homœopathic drugs is no indication that homœopathic prescribing is being done; or they may prescribe with so limited knowledge of the principles involved that while often a drug may be truly the indicated one, more often it requires long-con-

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tinued trials of different medicines in various potencies, the result being ultimately a fairly successful patch-work; but this success rarely adds to the glory of homœopathy or the enthusiasm of the prescriber.

Success in medicine is what every ambitious physician seeks, and to the homœopath success means successful prescribing, as being the fact which distinguishes him as a homœopath.

It is over the weaker contingent of our school that the "wave of discontent" has swept, and it is indeed because they have something to learn and are guilty of errors of ignorance. But the truths, the essential truths of homœopathy, are not being questioned by any very large part of the profession to-day.

Skepticism, be assured, is not rampant, and where it does exist it is like skepticism in many other matters, the result of either ignorance or prejudice, or both. But even the homœopathic malcontent, in spite of the protests, will be found clinging tenaciously to the few drugs that experience has taught him to understand and to make proper use of, and he blames homœopathy for his failures, and gives his own knowledge the credit for his successes.

We need not be alarmed, however, at these sporadic cases of discontent, although we may well deplore the lack of interest in the study of the materia medica by a large per cent. of the profession. There are many reasons for this. The chief one is that an understanding of homœopathic principles and of the materia medica involves great labor; like everything else worth having, it must be worked for, and physicians indisposed to unnecessary labor are to be found.

Astronomical calculations and discoveries are not made by experimentation, or by squinting through a telescope, but by a thorough understanding of world-wide, yea, universal principles, and further by laborious mathematical calculations. Therefore, in trying to restore the functions of a sick organ we must undestand and act according to universal laws. If, in astronomy, we regard gravitation, let us not disregard our law of cure.

Another reason is our growing dependence upon general measures. Surgery to-day steps forward as a possible means of cure in a large number of cases, and it is only too often resorted to as the least difficult solution of a difficult problem. Other means of cure are massage, hydrotherapy, dietetics, and, like the allopath, too, many homœopaths are deserting drugs for these general, and, in their place, important measures.

And last, but by no means least, is the faulty form of the compiled materia medica and the manner of its teaching. The remedies for these conditions are self-evident, but aside from these, one need is a revision of the materia medica and the philosophy of homœopathy.

Revision of any well-understood work cannot harm the truth, and it can be improved by the elimination of that which time and experience has shown to be unworthy. The chief errors of our materia medica are not errors of truth, but awkwardness of statement, which misleads in the interpretation of the true symptoms. Much needs re-statement in harmony with our modern knowledge of disease as revealed by our modern diagnostic methods. We recognize to-day many conditions, the facts regarding which find no expression in the materia medica, either in its clinical or pathogenic symptoms.

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We need better interpretation of the symptoms we have, and more extensive indications of the clinical verifications. Reprovings are needed, and in these reprovings let the chaff of language be blown away, needless repetitions avoided, and statements simplified. Pathology, bacteriology and physiology ought not to be ignored, and the anatomy should be modernized to the extent of more intelligible location of pains and other symptoms. Diagnostic methods are not to be ignored as unimportant to the homœopath, for many a time homœopathy has failed, and, with downcast head, has met the approbium of the "regular" school, because the condition was not recognized.

Lumbar spinal curvature was once found in a case which had been treated continuously for kidney trouble, because of the symptoms which accompanied the deformity and were the result of it.

The true nature of the heart-lesions should be recognized; the urinary analysis is not without its significance; the blood-count should mean something when the materia medica is reproven and revised along the lines of modern medical knowledge. It may be objected that these facts are already to be found in the materia medica. Yes, perhaps they are implied, but they need expression.

Another matter which needs emphasis is the importance of mental symptoms. Hahnemann long ago directed attention to the mental phenomena which most cases of disease present, and it is a significant fact that books of the regular school to-day, on diagnosis and practice of medicine, call attention to the peculiar mentality of certain diseases as being important in the recognition of bodily conditions.

There is a growing belief in the inter-relation of body and mind.

There are schools and sects whose enthusiasm has driven them to ridiculous lengths, but a rational view of this relation cannot but be an important consideration. There are no symptoms more easily obtained and none assist more in the necessary individualization of the case. There is nothing so striking in the provings of our drugs as their mental individuality. *Nux, pulsatilla, chamomilla,* are unmistakable so far as their mentality is concerned, when often the attendant symptoms are obscure. If we believe in the individuality of the patient—and we must and do—so also must we learn, aside from their physiological action, the individuality of our drugs. They must not only possess, to our minds, individuality, but absolute personality, something to be recognized as we recognize a friend by gait, by voice, by manner, attitude, even by a written thought. The mentality is what molds the personally and individually of our acquaintances, so also does it make the personality and individuality of drugs the more striking.

And now, as to the methods of teaching and of studying the materia medica. It would seem that in medical schools the methods of teaching and of study do not at all conform to the methods in vogue in the teaching of other sciences, and that we forget that since first-year students are not children, they need, nevertheless methods suited to the comprehension of beginners. Modern pedagogical methods must be used, simple, basic ideas and terms must first be presented upon which, by a "cumulative" method, the superstructure of facts is to be built. In no way can this rational method be so easily used as by the use of a series of graded text-books of materia medica for the various years

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of the college course. The large tomes containing all the well-authenticated knowledge of the materia medica may be, in the hands of the experienced prescriber, the *ne plus ultra,* but to put such a work in the hands of the beginner is a travesty on all pedagogic common sense.

The failure of many a practitioner is due to his failure to know the drug as one suited to the conditions he sees in actual practice. Repertory work cannot always be done, and must not always be depended upon. The practitioner must depend first upon his recognition of the condition of his patient, his examination must in his own mind classify his patient, some few symptoms of the more particular sort must confirm his diagnosis, or approximate diagnosis. Every patient must belong, in the mind of the physician, to some particular category, then must come from a particular class of drugs his selection, confirmed by whatever guiding symptoms, general or particular, subjective or objective, may present themselves.

It is obvious that there is, therefore, no use in demanding a mere study of drug symptomatology. The study of drugs must be a study of the application to diseased conditions, and we must proceed as if considering a case of disease from generals to particulars, from basic ideas to those which are complementary.

As to homœopathic philosophy, that it is essentially true no one doubts, and not a true homœopath would willingly see one jot or tittle of the truth destroyed, but it does need revision and rewriting. It cries out for rescue from the insults of a critical profession because of its antiquated psychology, and is grossly misinterpreted by reason of its quaint views of essential truths. To the student unacquainted with the essential truths, by experience, they appear incomprehensible. It has an atmosphere of sophistry. It must be stated so as to be comprehensible to the modern physician. Explanation of the phenomena of disease can be better made with the present knowledge of diseased conditions.

In propagation of the truth we must not force upon the unbeliever an indiscriminate use of such terms as *ego, vital force, dynamics, psora, sycosis,* without adequate and intelligent comment. There is no work containing truth that time cannot better by revision. It would be a pity not to revise it when its own author did so five times within his own life, and it is a reflection upon the profession of to-day if, in almost a hundred years, they have discovered no errors and have added no fragment of truth nor made an old truth plainer. Harsh criticism and skepticism are the lashes which goad us on to progress. Old truths are ever freshest in the garments of new expression. Truth, even if crushed to earth, will rise again, new-clad and more glorious.

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A STUDY OF NATRUM SULPHURICUM

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Natrum Sulphuricum is one of the valuable neglected remedies of the homœopathic materia medica. Since its first discovery in 1658 it has been used as a laxative and purgative, displaying properties similar to those of other alkaline sulphates. It constitutes an active ingredient of most alkaline spring waters, both natural and artificial, and as such its use has been greatly abused.

The first provings were made by Schreter and later by Nenning. These provings were published in 1832 and 1833, and in 1873 were arranged with Lembke's later provings and such other material as had come to light, and published as a monograph by Dr. Hering. Little has since been added to the literature of the drug. Probably the most important deduction as to the clinical virtues of the drug is that of Von Grauvogle, who, in his "Text-book of Homœopathy," published in 1866, proclaims *natrum sulphuricum* as typical of what he calls a "hydrogenoid constitution," a term which he very appropriately applies to a class of patients who have too much water in their systems, and whose conditions are always distinctly aggravated by damp weather and damp locations. He maintains that such patients usually present a previous gonorrheal history, and that there is a distinct relation between the conditions thus presented aad that termed "sycosis" by Hahnemann, as well as the more commonly known leukemia. That the drug has proved useful in such states cannot be denied, but to the homœopathist the only practical indication lies in the aggravation from damp weather, and damp conditions in general. Many forms of disease with such a history, including one case of diabetes, are reported as having been cured by *natrum sulphuricum.* It is interesting to note that many cases of the so-called "uric acid diathesis," which at the present time seems exceedingly prevalent, and which is accredited with being the source of numerous ills not otherwise easily accounted for, present the history of many of the characteristics of Von Grauvogle's hydrogenoid constitution. In such cases *natrum sulphuricum* has often proved a valuable remedy. T. F. Allen says it is "a great remedy for lithemia;" and no doubt it is. Doubtless if we were to depend more upon this and other well-indicated homœopathic remedies in the treatment of the protean symptoms that are supposed to result from the presence of uric acid in the blood, instead of adopting the eliminative methods of the old school (with well

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advertised eliminating agents of very doubtful efficacy) we would obtain much greater success.

Rheumatism, whether due to uric acid or not, when there is a decided aggravation from dampness, finds in *natrum sulphuricum* a valuable remedy. The symptoms of the drug are remarkably similar to those of sciatica and other affections of the hip-joint, and it has proved efficacious in such cases when the characteristic modality was present. Any neuralgic or rheumatic affection brought about by living in a damp house, or by working more or less continuously in a damp atmosphere, such as in a cellar or an ice-house, will often be relieved or cured by *natrum sulphuricum.* The same remarks hold true in catarrhal conditions, no matter what mucous membranes are involved. In nasal, bronchial and enteric catarrh *natrum sulphuricum* has often proved valuable. In nasal catarrh there are bloody, offensive discharges. In bronchial catarrh the drug is most useful when asthmatic symptoms prevail, with great dyspnœa and oppression. There is usually pressure and stitches in the left side of the chest. The cough is usually dry, or there may be a glairy expectoration. The symptoms are usually worse at night, and relief is obtained by the patient sitting up and holding the chest with both hands. Many cases of asthma, evidently bronchial, have been reported as cured by this drug. Probably nowhere else is the aggravation from damp weather a more necessary indication. There is no evidence that *natrum sulphuricum* is of any special value in tuberculosis, yet many of its symptoms, including those of bronchial asthma, above mentioned, seem to point that way. Hering says a kind of phthisis, not a true tuberculosis, in those of a hydrogenoid constitution, with mucopurulent expectoration, loud rales, the lower lobe of the left lung most affected.

Enteric catarrh, with a diarrhea of thin, yellow stools, always worse in damp weather, and also after vegetable and farinaceous foods; always worse in the morning after moving about, and associated with great flatulence, soreness of the liver, and often other hepatic symptoms. *Natrum sulphuricum* produces very pronounced liver symptoms, and has proved useful in various biliary disorders. Sensitiveness in the region of the liver is a common symptom; sensitiveness to touch, or on stepping hard, or from a jar, or on deep breathing, sneezing or coughing. Sometimes the liver feels tense, as if it would burst open; stitches in the liver are also of frequent occurrence. In this connection it is proper to notice an important modality—worse when lying on the left side. This is a general modality of *natrum sulphuricum,* but is especially noticed in connection with the hepatic symptoms of the drug. As might be presumed from the symptoms above mentioned the remedy has proved useful in subacute and chronic hepatitis, and various functional hepatic

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disturbances, including catarrhal jaundice. In such cases there is often vomiting of bile, a grayish or greenish brown tongue, and diarrhea. One of the most prominent clinical uses of *natrum sulphuricum* is in acid dyspepsia, especially when there is considerable heart-burn and flatulence. In all gastric derangements characterized by acidity this drug is said to be carefully considered. It is said to have been curative in typhlitis, probably what would now be termed appendicitis. However, in my opinion, it is altogether likely that such cases were flatulent colic, affecting the right groin. In fact many cases now diagnosed as appendicitis are only colic, pure and simple. Such cases may develop mild inflammatory symptoms, and if so *natrum sulphuricum* is none the less indicated. The drug has proved useful in cases of violent bilious colic with excruciating pains, vomiting of bile and bitter taste in the mouth. Abdominal flatulency is certainly a very important feature in the action of the drug.

There are other conditions of less importance in which *natrum sulphuricum* has been reported as useful. One of these is earache, with lightning-like stitching pains, when coming on from exposure to damp weather. Another clinical symptom upon which considerable stress has been laid is "toothache better from holding cold water in the mouth." This reminds us of *bismuth, coffea* and *pulsatilla.* I have little confidence in such symptoms. Indeed, I think most of the "toothache" symptoms of our materia medica are unreliable. I have never yet been able to cure toothache in a carious tooth with homœopathic remedies, or any other remedies, for that matter, outside of the proper manipulations of a dentist.

Natrum sulphuricum presents many eye symptoms, and has, no doubt, proved useful in granular conjunctivitis, but I think only when present in sycotic subjects. There is always acrid lachrymation, sensitiveness to light and agglutination. There are symptoms like those of panaritium, and Hering recommends the drug where the pains were more bearable when out-of-doors. This is another symptom in which I have not much confidence. I never saw a case of felon where the pain was not seemingly better when moving around in the open air, nor have I ever been able to materially palliate the excruciating pain of this affection with ordinary remedies, no matter how well indicated they may have been.

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THE DUAL CHARACTER OF DRUG USAGE

E. M. Howard, M. D.
CAMDEN, N. J.

It is natural for the lay mind to look upon all drug-action as alike, and to consider the use of any prescription as simply "taking medicine." Some people speak of the various prepared foods as "medicines," while others mean by the expression "taking medicine" that they are using purgatives. It is evident that there is neither public appreciation of the character of drug-action, nor of differences in the purposes for which they are used.

The medical profession itself should discriminate more carefully in these matters, but the fact that it ofttimes fails to recognize the underlying philosophy of drug application, or to consider the possibility of at least *two* distinct ways and purposes of using them, is the excuse for the preparation of this paper.

Many of the misunderstandings between medical men, and some of the present differences between the two great schools of medicine, hang upon a failure to appreciate this diversity of drug action. Recently a homœopathic physician was denounced publicly by an old school brother because he had used *digitalis* as a heart-stimulant in the treatment of a case of diphtheria. It was claimed that by so doing he had forfeited all right to call himself a homœopath, and that he had bodily gone over to the old school, and could no longer honestly claim a distinctive name.

I presume there are homœopathic phyicians who would make the same criticism, while there are others who, feeling that it is right to use heart-stimulants in such cases, do not exactly know their ethical position in so doing. A right appreciation of the dual possibilities and facts of drug-usage will end such criticism and remove all doubts.

A clear understanding of the thought under consideration can be had by reference to the manner in which different physicians treat *condylomata*. The surgeon may remove these sycotic excrescences by either one of two mechanical ways; he may cut them off with his knife, or he may destroy them with some cauterizing drug. Suppose he uses *nitric acid;* this burns them off by chemical action, but the effect is a mechanical one, and is exactly parallel with their destruction by the knife. It is an example of the local use of drug powers for a distinct mechanical purpose.

The physician will treat these same *condylomata* by giving some drug internally in small doses, which, by the changes it brings about,

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removes the cause of the condition. *Nitric acid,* as well as some other drugs, are known to bring about such changes.

It is plain, therefore, that there are here *two* distinct ways of using *nitric acid* to relieve a patient of *condylomata.* The first makes use of its local caustic effect for the production of a purely mechanical result. It is comparable to the surgical procedure, and is governed by the physical laws of chemistry and mechanics. The second is a curative action of the drug, produced by changes of the vital processes, in ways at present unknown, but most certainly conformable to some law of nature, and intelligently explainable in accordance with the law of *similars.*

Now, what is true of *nitric acid* is true of many drugs in a similar way, and it is also true of great numbers more, in one respect, namely, that their most marked physiological effects are used to bring about well-defined mechanical results. For example, purgatives, because of known effects, are used to obtain the definite mechanical result of emptying the bowels of their accumulations, or of draining water-logged tissues. Diuretics, because of their known stimulant effect on the kidneys, are used for the definite mechanical purpose of relieving dropsical conditions. Emetics, some of which act mechanically and some physiologically, are used for the avowed purpose of mechanically evacuating the stomach. Mydriatics and myotics, because of their peculiar physiological action on the eye, are used for the definite mechanical object of changing the size of the pupil, of dragging the iris out of danger, or of paralyzing the power of accommodation. Opiates and anesthetics, because of their physiological benumbing power over the nerves, are used for the distinct mechanical purpose of rendering the patient unconscious to pain. Digitalis and other heart-stimulants are used for the express purpose of forcing the heart to greater mechanical action.

Many of these drugs are known to be, and all of them may possibly become, curative drugs in other conditions, and in ways not explainable on mechanical grounds, and so, like *nitric acid,* illustrate the fact that there is a duality of drug-usage which must be recognized, and which is a matter of practical therapeutics, entirely outside of and distinct from the usual study of drug symptomatology.

The following are a few of the many specific illustrations that may be drawn from the pages of any old-school work on materia medica:

Podophyllum is a valuable purgative, and is used for this mechanical purpose. It is known to be curative in certain forms of diarrhea. Aloes is used as a purgative, and is also curative in rectal troubles with loose bowels. Colocynth is a hydragogue cathartic, and so useful in chronic dropsy mechanically; it is also curative in certain neuralgias. Cina and spigelia have a mechanical effect in the presence of round worms; and their curative effect in digestive troubles is well attested.

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Ergot is used to produce contractions of unstriped muscular tissue, but it is curative in gangrenous troubles, and this action cannot be explained on mechanical grounds. Arsenicum, by its local mechanical action, will heal ulcerative skin-troubles, and it will also cure chronic skin diseases when taken internally in minute doses. Tartar emetic will mechanically empty the stomach, and it is also curative in bronchial catarrhs. Nitrate of silver is a caustic and astringent, and is used for these purposes. It is curative in nervous and other conditions which cannot be explained on a mechanical basis. Mercury produces notable mechanical effects, but its curative results in syphilis cannot be explained other than by the law of *similars*. Strychnine is a wonderful heart-stimulant, mechanically useful, but its cure of catarrhal dyspepsia and dysenteric troubles is not so easily explained.

But why multiply examples? Reference to any old-school authority will show that while an effort is made to develop drugs in the direction of producing some definite mechanical modification of physiological processes, there still remain large spheres of their influence outside of such action, and many drugs, also, which cannot be so developed, but which have been empirically discovered to have curative effects, and are even considered as specific in certain conditions, concerning which they do not seem to have any rational connection.

It is most gratifying to our school to know that all such curative effects can be shown to be in strict accordance with the homœopathic law.

In this connection it is interesting to note the status of that class of drugs known as *alteratives,* of which Potter states that "they alter the course of the morbid conditions in some way not yet understood—perhaps by promoting metabolism."

The list given includes the following: Arsenic, antimony, aurum, mezereum, sulphur, ichthyol, mercury, colchicum, guiacum, sanquinaria, calcium, iodine, the iodides, cod-liver oil, and phosphorus.

The empirically-discovered value of these drugs as curative agents is amply corroborated by homœopathic experience, and explained in accordance with the law of similars.

It would appear, therefore, that there are but two therapeutic usages recognizable. Either their results are explainable on purely mechanical grounds, or the improvement is produced by some occult influences upon vital processes, in ways not at present accounted for.

It would also appear that mechanically explained drug results are those produced upon the function of organs taken en masse, while the curative ones are such as are produced by changes in the individual cells of the organs and tissues, and so are beyond the ken of human observation.

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For the purpose of further study we might make three groupings of drugs. First, such as are used solely for the production of mechanical results.

Second, such as are never used for mechanical purposes, but which experience has shown to be beneficial in diseased conditions.

Third, all drugs that offer the two distinct forms of usage we are discussing.

Any attempted grouping of this kind will, however, be tinctured by individual theory and practice, so that no two physicians would make exactly the same classification. The fact is that here we arrive at the exact parting of the ways of the two great schools of medicine. The old, or rational, school of to-day would seek to explain all curative results physiologically, and it bases all prescriptions upon the desire to bring about definite mechanical results. Such a system presupposes perfect knowledge of pahological changes, and a clear understanding of the steps necessary to restore health. It would plead the limitations of present knowledge as the excuse for our inability to base all therapeutics upon such mechanical grounds.

The homœopathic school of to-day recognizes the usefulness of many, if not the most, of these mechanical measures, but believes that the mysteries of nature will never be fully revealed, so that such means cannot become universally applicable, and that in the law of similars we possess a guide to curative effects which will never fail us in the presence of these deeper and most occult cell-degenerations.

These considerations lead to a view of therapeutic philosophy somewhat different from that usually taken. For instance, the use of digitalis as a heart-stimulant is not an evidence of the existence of any law of cure. It is simply an example of practical mechanics; not enough blood being pumped, put on more force and pump more blood. The fact that in this instance certain physiological forces are used which happen to have antipathic relationships would singnify nothing. Certain prominent physiological powers of drugs are used to produce definite mechanical effects, and there is no law of cure or rule of practice involved, any more than when a splinter is removed from the flesh. Either measure may relieve a patient of suffering and offer an opportunity for a cure, but neither is a curative measure.

The question as to the advisability of such applied mechanics by means of a physiological drug power must be studied in the light of the possible drug-effects upon the patient's system in other directions, and its pro's and con's must be weighed as we do those before any surgical procedure.

In the homœopathic school it would seem that this question of therapeutics has become confused with, and obscured by, the study of drug

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symptomatology. The introduction of the terms *primary* and *secondary* as applied to drug-effects has proved most unfortunate. It is impossible to draw any such dividing line. Drug action is one continuous chain, of which each symptom is a link so intimately connected with those preceding and succeeding, that it is impossible to separate them. The weak heart developed by the provings of digitalis is simply the last link in the chain which began with stimulation and ends with paralysis.

For the purpose of a homœopathic prescription it is necessary not only that we should know the entire range of the symptoms produced by a drug, but must study their sequence of development. Any group of such symptoms taken from any stage of such sequence may point to the use of that drug in a similar condition, at a similar stage of development. Thus, it might possibly happen that digitalis might be the homœopathic *similimum,* in the very case in which it is being used for its mechanical effect, and so exert a curative as well as a mechanical effect at one and the same time. This thought would carry the idea of the duality of drug usage to its last limit, and is perhaps too fanciful for practical consideration.

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THE RELATIONSHIP BETWEEN "THE SCIENCE OF THERAPEUTICS" AND OTHER SCIENCES

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More than twenty years ago I made a prediction to the students of Hahnemann Medical College, of Chicago, that many of their number would live to see the day when science, not contemplating homœopathy, would demonstrate not only the truth of the "science of therapeutics," but also of its chief corollary—the potency of infinitesimal dose.

I made the prediction because I knew that both propositions were true; and that Time, the great friend of Truth and enemy of falsehood, would surely so demonstrate. And so it has.

I use the title "Science of Therapeutics" as synonymous with "Homœopathy." Carroll Dunham has so defined it. Nor was he, nor are we, presumptuous in so calling it, for it is the science of therapeutics, and there is none other.

Like other inductive natural sciences, it possesses the necessary two series of independent phenomena connected by the formula of their general relation: symptoms of the sick—therapeutic law—symptoms of the drug.

It possesses also the two essentials of such a science:

First. The capability of infinite progress in each of its elements, without such progress involving the destruction or denial of what has been previously constructed or received.

Second. It furnishes means of *prevision;* it provides for the prediction of future events within its own domain.

The astronomer, for instance, by means of the science under his law, predicts the hour of appearance of a comet which returns but once in many years, and locates new stars, as in the discovery of the planet Neptune.

The science of therapeutics, to be such, must be able to do likewise, that is to say: given certain phenomena (symptoms of the drug) it must be able to predict certain results with respect to certain other phenomena (symptoms of the sick) from the action of drugs administered under its direction. This it does.

Hahnemann himself furnished the most notable examples of this prevision in connection with the first epidemic of Asiatic cholera in Europe in 1831-1834. Before the dreaded disease had reached Germany, and while yet neither he nor any of his disciples had seen a single case.

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he predicted that certain remedies, at certain stages, would be indicated and curative.

Dudgeon, in his lectures on homœopathy, says:

"Hahnemann, guided by the unerring therapeutic rule he had discovered, at once fixed upon the remedies which should prove specific for it, and caused directions to be printed and distributed over the country by thousands; so that on its actual invasion the homœopathists and those who had received Hahnemann's directions were fully prepared for its treatment and prophylaxis; and thus there is no doubt many lives were saved and many victims rescued from the pestilence. On all sides statements were published testifying to the immense comparative success that is founded, than almost any other I could offer, *viz:* that Hahnemann, before he had seen or treated a single case. This one fact speaks more for homœopathy, and the truth of the law of nature on which the system is founded, than almost any other I could offer, *viz*: that Hahnemann, from merely reading a description of one of the most appallingly rapid and fatal diseases, could confidently and dogmatically say, such-and-such a medicine will do good in this stage of the disease, such-and-such other medicines in that; and that the united testimony of hundreds of practitioners in all parts of Europe should bear practical testimony to the accuracy of Hahnemann's conclusions."

The well-known "Chapman case" is a good illustration of the fact that the science of therapeutics is truly a science. In this instance identical letters were sent to ten representative physicians of both schools in as many of the large cities of the United States requesting a prescription for an ailment characterized by certain described symptoms, and asking that the name of the remedy be given with each prescription.

I was the homœopath, and Dr. Parks, since deceased, was the allopath, selected from Chicago.

The result was that all of the ten homœopaths prescribed the same remedy—*lycopodium*—and all of the ten allopaths prescribed different remedies, and two of them prescribed proprietary drugs.

It would be difficult to conceive of a more striking contrast between the results of scientific accuracy and blind guess-work. It is at least improbable that ten physicians in as many widely separated cities, and all unaware that others were connected with the case, could have *guessed* the same conclusion. The only fair inference is that a scientific rule guided them to the unanimous conclusion; moreover, a similar test can be applied at any time with the same result.

It was a strange explanation of the unanimity on the one hand and diversity on the other that was offered by one unacquainted with and opposed to the science of therapeutics, when he said the result showed that the homœopaths were limited to one remedy for dyspepsia, while

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the allopaths had at least ten! With the poet, we are constrained to say:

> "Judgment, thou hast fled to brutish beasts,
> And men have lost their reason."

In so far as scientific investigation and discovery of new truths, under whatever law, have affected the science of therapeutics, the result has been in every instance to uphold it. In no instance have they tended to overthrow the truths of homœopathy, nor weaken its claims as a guide to the healing of the sick.

Where such has seemed to have been the case, it was when the science of therapeutics was confounded with some other science, as Hygiene. It is a common mistake to confuse hygienic measures, methods and causes with those of therapeutics.

The science of therapeutics has to do only with the administration of medicines for the *cure* of the sick. Note well the distinction. All other measures resorted to by the physicians for the relief of the suffering properly fall under some other head.

The microbic cause of disease, whether universally true or not, has no bearing whatever upon homœopathy. What it teaches relative to sickness is a lesson in hygienic cleanliness—no more, no less. Yet we hear asserted often by weak-kneed homœopathists, with fear and trembling, that the truth of the microbe theory of disease is the death-knell of homœopathy. The assertion and the fear are absolutely without foundation.

The best preventive against disease, whether or not the cause be a microbe, is *perfect health* of the individual. Microbes have about as much chance of damaging a healthy body as bird-shot a battleship. It is only the sick body, the defective constitution, that the microbe effectively attacks.

But the function of medicine is to bring the body to as nearly as possible a perfectly healthy condition. And the science of therapeutics teaches how to apply medicines so as, in the best manner, to accomplish this chief end. Hence, the truth or falsity of the microbe theory of disease bears not at all at any point on homœopathy; as was said before, it is a hygienic question, pure and simple.

The sciences of hygiene and therapeutics are the twin hand-maidens of the up-to-date physician in his work of preventing disease and curing the sick; and are in no sense antagonistic. The sphere of the former is in preventing disease by perfect cleanliness and proper living. The function of the latter is the curing of the sick where a non-observance of hygienic laws has allowed disease to establish itself. They must go hand in hand. The physician who fails to apply the one and enforce observance of the other to the best of his ability falls proportionately short of

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having done his full duty. Yet how many are lax to a lamentable degree in the matter of enforcing observance of the laws of hygiene!

The discovery of new coal-tar hypnotics, and the like, has no bearing on the question; yet I have heard the charge of illiberality made against homœopaths because they decried the value and use of such.

Serum-therapy has been held up as a bug-bear to homœopaths, without good reason. If there is truth in serum-therapy it would seem to be along homœopathic lines. It is surely much like *vaccination*—inducing one diseased condition to cure or prevent another. Antitoxin, as a cure for *diphtheria,* is the most common form of serum-therapy. In regard to its efficacy for good, I can, from personal experience, say nothing. Those advocating its use quote volumes of statistics to show that since its introduction into medical practice the percentage of deaths from diphtheria has been reduced at least one-half, and are loud in its praises.

The sound of their praises had scarcely died away in the distance when up steps a company, serene and confident, who assert that there is no good in it. And *they* quote as formidable an array of statistics showing that the count was padded; that, since antitoxin came into action, the proportion of cases in a given locality diagnosticated as diphtheria had increased more than a hundred per cent! and claiming that the remarkable increase was a result of inaccurate diagnosis *a la* microscope.

A witty one was asked who were the three greatest liars of record. His reply was "Annanias, Tom Ochiltree, and *Statistics!*"

Within a month I was in consultation with a homœopathic physician over a case of diphtheria in a child. He said he invariably used antitoxin in treating this class of cases. There were two children in this family down with the disease. The doctor had already injected what he considered a full quantity into both patients. One seemed to be doing well; the other was getting worse under the treatment. This, he informed me, had been his experinece ever since he began its use, *i. e.,* some case it would seem to help promptly, while in others, regardless of severity, it would seem to have no effect whatever. He instanced one family where five members—all children—had diphtheria, all had antitoxin from the start, and all five had died! the antitoxin having apparently no effect whatever in arresting the disease.

This physician confessed, while discussing the question of padded diphtheritic statistics, that he had in at least two cases diagnosticated diphtheria "when he didn't think it really was!" and excused it by saying he "wanted to give the patient the benefit of the doubt!"

The unexpressed query in my mind was: how much benefit did the patients derive from the doubt?

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The experience of a well-known professor in a Western college may serve to further illustrate the way the remarkable proportionate increase in the number of cases of diphtheria came to happen: Professor T. had living doubts both as to the accuracy of something in connection with these statistics, and the science and efficacy of the antitoxin treatment in diphtheria. He is also regarded as authority on all diseases of children. A servant in his house had sore-throat. He did not regard it as diphtheria, but was uncertain. He carried a sample of the exudate and the saliva to the health office of the city for microscopic examination to ascertain whether or not it was diphtheritic. The health officer's report was that it was undoubtedly a case of that disease. The girl recovered promptly, and the doctor was and, I believe, still is of the fixed opinion that it was not. He next took a sample of what he could find in the mouth and throat of an apparently perfectly healthy member of his household to the same health officer, and received a similar report, viz: that the subject from which was taken this second sample had diphtheria. He then took a specimen from the mouth and throat of a large and perfectly healthy dog to the same health officer, and received a report similar to the other two!

The doctor was and, I believe, still is of the opinion that there is considerable humbuggery about the diagnosticating of diphtheria in health boards by means of the microscope!

The lesson to be learned from this physician's experience, as well as from what statisticians tell us, and what they do not tell us, is that, even though it be conceded that the antitoxin treatment cured some cases, yet the fact that it fails in any case shows that it is not a cure-all in this disease, and that thus far there is no means of knowing the distinguishing features of the case it can cure from those of the one it cannot cure; hence it is a matter of no higher scientific value than common, every-day guess-work, upon the possibilities of which there is injected into the life-blood of innocent children an unknown, unclean substance, the principal ingredient of which is pus from a diseased horse! And all in the name of science! And in this day and generation of ultra aseptic and antiseptic surgery, when everything in the operating room except the doctor and the patient and the doctor's whiskers and the microbe-laden air of the room is boiled and bi-chlorided to an absurd degree lest, perchance, a microbe or two might be lurking there!

If antitoxin is to be used at all, the only scientific course to adopt in order to determine when it shall be used is to prove it! Hahnemann's, now as ever, is the only right way to ascertain the curative sphere of any substance which is brought forward as a curative agent. How many, think ye, of the doctors who so freely inject the dirty stuff into the

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blood of the innocent would be willing to act as provers and take the substance in the same manner as they give it to their patients?

It seems to me that a careful review of the facts will show to the unbiased that the charge against consistent homœopaths—that they are unscientific and guilty of illiberality because they repudiate serum-therapy in its present pseudo-scientific state—will not hold, and that, on the contrary, the illiberality and lack of science is on the other side.

Perfect health being the best prophylactic, and the science of therapeutics being the best-known means of restoring perfect health, the homœopathic physician who is consistent and knows his business is convinced that he has a surer, safer and more scientific means of curing those ill of this most dreadful disease than any other now known.

Yes, I am free to say that I for one would gladly welcome and use antitoxin or any other agent that would enable me to cure every case of diphtheria. For I acknowledge my inability to do this by any agents of which I, at present, have knowledge.

Hygiene is the only science which is at all closely related to the science of therapeutics in the cure of the sick and the prevention of disease. It may be a disputable question as to which is of the greater importance. Hygiene (and by hygiene is meant cleanliness and proper living in their broadest meaning) is certainly the more important agent in the prevention of disease, and I am of the opinion it is of at least equal use in the cure of the sick. A rigid compliance with the laws of hygiene, moral as well as physical, would in time eradicate disease entirely from the human family. To be sure many generations would doubtless be required for its accomplishment. A much shorter period would be required were the science of therapeutics and hygiene to go ever hand in hand, as they should.

All the pathological facts developed during the past decade with respect to disease causation, and especially the relationship of the microbe thereto, encourage me to proclaim that which I believe to be true, *viz:* that *all disease, recent and remote, has been caused directly or indirectly by filth.* The term is used in its broadest sense.

Disease-producing microbes are filth or its product.

Geologists tell us that at one period in its existence the earth was altogether inorganic; that there was no life on it. *This we believe—yea, know—to be true.* Hence life, disease, microbes, must have come to, or have been developed upon its surface.

In the light of evolution it is not conceivable that a destroyer of life should appear before life itself. Hence we must conclude that life came before disease or its cause. It would outrage all reasonable conception of the purposes of nature to suppose that she could create with

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the purpose of growth and perfection of the creature and then create also its destroyer.

Life, under law, came first. Disease and the microbe (which first?) came next, as a result of a breach of nature's law.

It is not my purpose to enter into a discussion as to whether or not the microbe is more an *effect* than a *cause* of disease, but it does seem to me as though at least in the beginning the preponderance of evidence is in favor of the view that it was a result rather than a cause.

Take a number of healthy monkeys, rabbits and guinea pigs, fresh from their natural haunts and free from all disease-producing germs, into the mountain tops, where the air is pure, and also free from microbes; confine them in more or less close and imperfectly ventilated pens.

How long will it be until they sicken with tuberculosis? And how long will it be before the microscope will find the so-called disease-producing microbes? And whence will they have come? Will they have caused the disease, or will the disease have caused them?

To such as have not considered the question, the claim that all disease originated from uncleanliness in some of its many forms may seem unwarranted by the facts. But I can think of not one disease that cannot be traced to some form of uncleanliness. We must use the term in its widest meaning. Over-eating, and generally unhygienic eating, causes disease by producing a variety of unclean conditions of the body. The diseases do not come, however, until after the unclean conditions obtain.

Civilization in its present state of advancement practices and almost necessitates modes of living which inevitably promote uncleanliness and cause disease. It is unclean to breathe into one's lungs one's own exhalations and excretions. Much more so to inhale those of others. But the houses and the schools and the public vehicles and the habits of civilization make this form of uncleanliness unavoidable. And it helps cause disease.

The experience recently of the health department here in Cleveland argues strongly in favor of the opinion that small-pox is a disease having its origin in filth. There would seem to be no room for question that its twin brother, *viz.*, syphilis, is a disease with no other origin than filth. Typhoid, typhus and yellow-fever surely are, as are also cholera, the plague, etc.

With the diseases mentioned, the connection between the cause and the result is immediate and apparent. With such diseases as tuberculosis, chronic rheumatism, cancer, scrofula, tc., the connection between the cause and the disease is not so direct and apparent, but it exists nevertheless. As I said before, I can think of no disease, not surgical, the

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origin of which, recent or remote, cannot be traced to some kind of uncleanliness, some breach of the laws of hygiene.

Therefore, I say that the hygienic law is the only one which is at all closely related to the science of therapeutics, and that an understanding and application thereof by the physician is of at least equal importance with an understanding and application of the science of therapeutics itself.

Further, I can conscientiously say that, from the highest standpoint of the physician as a preventer of disease and healer of the sick, had I to choose between the two and could have but one, I would choose the science of right living.

Scientific progress in late years in a remarkable degree sustains the proposition of the potency of infinitesimals. The infinitesimal dose has ever been the object of ridicule on the part of the opposition, and the greatest obstacle in the way of fair practical test. It was claimed that it was impossible for any part of the original drug to be in, say, the 30th potency, and that, therefore, the claim that it possessed curative power was absurd, and the breadth and depth of the ocean was called in to prove it.

Those who thus argued and ridiculed, yet failed to apply the only satisfactory test, experiment, proved themselves illogical. The eye unaided detects the drug in the 3rd potency; with the aid of the microscope it can trace the drug in the 9th potency; with the aid of the spectroscope it is still discernible in the 12th, but can we logically claim that, because the finest instruments science and art can furnish us in aid of our natural senses, fail to detect the material beyond the 12th, that, therefore, it does not exist? Surely not.

The "new chemistry" as taught in Harvard College, in whose halls once lectured homœopathy's dearest and most effective foe—Oliver Wendell Holmes—demonstrates the existence of the 23rd decimal potency. And it surely cannot be claimed that old Harvard is trying to uphold the medical heresy of homœopathy.

Professor Cooke shows that there are one hundred thousand million, million, million molecules in a cubic inch of gas, and that each of these smallest points of matter possesses all the attributes of its mass. These figures represent the 23rd power of ten, and correspond with our 23rd decimal potency. And even then the countless multitude do not fill the space of the cubic inch, but have room to "fly back and forth with inconceivable rapidity," and do so fly.

There has recently been discovered a new substance, called radium, a new element, which possesses light, intrinsically, to an extent ninety times greater than any substance previously known.

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Professor Thompson has shown, and his conclusions have been confirmed by others, that it gives off luminous particles which are less than one thousandth part as large as the molecules of hydrogen, which have hitherto been regarded as the smallest of all known substances. So small are these particles that the ceiling of a room twenty feet square would, according to Professor Becquerel, "give off only one two hundredth of a grain of radium in one thousand years. Supposing the amount required to cover such a ceiling to be one hundred thousand grains, the supply of light would not cease or diminish in less than one hundred million years."

Recent scientific discoveries show that "light itself possesses considerable mechanical propulsive force. That matter can be so *finely and infinitely sub-divided* that the propulsive force of light overcomes the force of gravitation, so that, acting upon this infinitely sub-divided matter, the propulsive power of the sun's own light overcomes its force of gravitation, and drives it into space."

I have heard intelligent homœopathic physicians in discussing the question of the potency of the infinitesimal dose, urge against the possibility of their believing in such potency that they could not conceive of any of the original drug being present in, say, the 30th dilution; that it was impossible of scientific demonstration; therefore they could not believe in its existence.

A much more marvellous yet universally acknowledged scientific fact is the *ether* which permeates everywhere and every substance, even the hardest steel. This mysterious, invisible, colorless, odorless, inconceivably rarefied something occupies every point of illimitable space. Its vibrations are electricity and light. When it vibrates 400 billions of waves a second we see red; when it vibrates 800 billions of waves a second we see violet!

Marconi, when he conceived the idea of trans-oceanic wireless telegraphy, could not demonstrate to the skeptic or the doubting (and they comprised all the world) the existence of material and tangible connection between the shore and the ship more than two thousand miles away, tossing on the bosom of the deep. Even such electrical wizards as Tesla and Edison were skeptical, and no wonder. To believe that man could, without material connection, talk with man over two thousand miles away connectedly and intelligently so that skeptical bystanders could hear and understand would be to strain credulity to the breaking point, and would be a much greater tax on the imagination than to believe in the curative results of a potentized drug.

In an article published in the 1884 volume of *The Clinique,* I asserted, while upholding and accounting for the potency of the minimum

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dose, that nerve action *was electrical;* whether or not the experiments and their results of Profs. Loeb and Matthews prove the possibility of parthenogenesis, their conclusions point not only to the fact that nerve action is electrical, but that electricity is the *basis of life force itself,* and that the medium of its transmission is probably the aforementioned omnipresent ether.

Their experiments were especially interesting to me, because of the remarkable effects of a solution of common salt—chloride of sodium—upon the action of the heart, and their explanations thereof. *Natrum muriaticum* is the medicine which taught me the truth of the claim that the 30th potency is actively curative, even when the crude substance is being used by the patient at the same time and is medicinally inert.

We must look alive or others will steal our thunder by first demonstrating to and convincing the world of the truth that infinitesimal, imponderable and—in their essence—unknowable influences are the most potent in nature.

Professors Loeb and Matthews arrived at the conclusion that it was the electrical condition of the molecules of the salt solution which caused its ability to affect the action of the heart muscles.

It has been known to the science of therapeutics for a hundred years that chloride of sodium, when its particles were *subdivided to an incalculably minute state,* possessed remarkable properties which were not exhibited in its crude state. The science of physiology is demonstrating the truth of these truths and is discovering others.

Whether or not Professor Loeb has discovered a process of creating life, he has certainly earned the gratitude of the scientific world.

And why should the claim that he had done so be regarded with incredulity and ridicule?

Life on the earth must have had a beginning *somewhere and somehow.* At one time, as we are told by geologists, the earth and everything on its surface were inorganic. At one time there was absolutely no life of any nature on this round world of ours. Hence life must have had a beginning. In accordance with the theory of evolution it must have begun with the lowest imaginable forms.

The spare-rib story about Adam and Eve will not answer; "The Testimony of Rocks" demolishes that. To unbiased reason it would seem that the only conclusion as to the origin of life on the earth is that it originated as a result of the action of chemical or electrical forces inherent in its substance. This would seem to be in line with the results of the experiments and conclusions of Professors Loeb and Matthews.

Homœopathy stands to-day with respect to fundamentals precisely where it stood one hundred years ago. It has been traduced and misrep-

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resented all through these years by those who did not know the truth, or, knowing, failed to respect it.

As a striking example of one or both, it is only necessary to quote from an editorial of Dr. Geo. F. Shrady within the last decade in the *Medical Record,* the leading journal of the old school in this country, in which he defines Homœopathy as "the theory that the more a drug is diluted, the greater becomes its power." Whether such an inexcusably false statement from such high educational authority be from ignorance or from a more reprehensible cause, the effect is the same—truth is for the time buried, and falsehood is spread broadcast in its name. But the Truth will not remain long buried. On the contrary, we find in all recent books on practice in the old school unmistakable evidence in abundance that they are fast learning that the true and only scientific way of learning the curative sphere of drugs is by testing their effects upon healthy human beings—not on animals.

The same is true of the saying of prominent essayists at national and international congresses of medical associations during the last few years. This is especially true of papers read at the Tubercular Congress. Pages could be quoted, did space permit, from such sources, in which Hahnemann's ideas—nay, almost his words—are freely expressed, but in no instance giving any indication that the authors had ever heard of Hahnemann or read his writings.

In conclusion I make another prediction, *viz.*, that many of the younger among us to-day will live to see the time when the principles of homœopathy, "the science of therapeutics," will be acknowledged and the art practiced by educated physicians the world over.

DISCUSSION:

J. P. RAND, M. D.: The relation between the "Science of Therapeutics and Science in General" is akin to the relation between a living stomach and a dead crucible. The chemist puts certain ingredients in his retort, and, given a definite mixture and a known temperature, he will get uniformly the same result. But when you put drugs into a human stomach, you have a receptacle that is both active and passive, and until you know more than it is possible for any one but the Creator to know, you can't be sure of the result.

There is such a thing as a science of chemistry. Formulas may change and theories may be discarded, but the combination of the various minerals and salts will remain the same. But the human body is subject to endless variations. No two persons are exactly alike, and you cannot be sure that they will respond exactly the same to the action of drugs. Even the same person at different times will not, as proved by the evidence of many observers.

I think that the Doctor has begged the whole question in his assumption that there is any such thing as a *science* of therapeutics. *Science* implies actual knowledge. Does the Doctor, or anybody else,

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know absolutely how any drug will affect the human body in a given case? Can he or anyone else explain why *rhus tox.* is highly poisonous to some and not at all to others? Therapeutics is an *art,* closely bordering upon what is understood as a *science,* but never quite attaining it, and, as the Doctor affirms, is capable of unlimited development. Homœopathy, with its system of drug-proving, its exhibition of the single remedy, and its application to the totality of the symptoms, has touched the high-water mark in medical therapeutics. Serum-therapy perhaps comes next. But the multiform mixtures of the dominant school, and, for that matter, the compound triturate tablets as employed by many homœopaths, are as far from representing any "science" in therapeutics as boarding-house-hash is from representing any science in cookery.

Then too, the action of the mind upon these sensate bodies of ours has a tremendous influence upon the effect of drugs which we administer to our patients. We do not pose as Christian scientists or mental healers; we may even deny the existence of any such thing as mental therapeutics, and ascribe all our results to the wonderful effect of "the indicated remedy." But we all practice them just the same. The patient's belief in his physician, and the physician's belief in his ability to cure, are as truly factors in bringing about a successful result as the drug prescribed—perhaps more so—and no one can measure these forces exactly, or determine their influence in any individual case.

We are mental healers, whether we acknowledge it or not. When we tell a patient, "You are feeling better to-day," we have re-enforced our prescription by mental therapeutics. The man does not live who could actually believe he had taken a deadly poison without being affected by it! In like manner, every patient who takes a "placebo" is affected. The faith of the patient is as truly an active therapeutic agent when it is pinned upon a drug as when it is fastened upon persistent prayer or an amulet!

Until you can comprehend what we understand by the vital force; until you can reduce this wonderful mechanism of the human body to the dead-level of a chemical retort,—you can really have no science of therapeutics, and if there is no science of therapeutics there can be no relation between it and anything else.

But, after all our definitions, the facts remain the same. It really makes no difference whether therapeutics is a science or an art, and the Doctor has surely given us a most excellent paper from the popular professional standpoint. It is well to set our mark high even if we never reach it. We all wish medicine was a science—an exact science. Some day it surely will be more exact than it is now. We need have no fears for the future of homœopathy or for any other fact in medicine. Truth will remain! Facts never contradict! Whatever in our system of therapeutics is false will pass away, and we ought to be glad of it. Whatever is true will remain, and every genuine discovery in the future will confirm and sustain.

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SECTION IN

GYNECOLOGY

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SECTION IN GYNECOLOGY

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THE RELATION OF SURGERY TO GYNECOLOGY

O. S. RUNNELS, A. M., M. D.
INDIANAPOLIS

Knowledge is gained by observation of facts. Worthy conclusions are formulated only after ample consideration of all the testimony obtainable in a given case. The analytical mind and the utmost that can be known concerning any problem are complementary, and both are necessary to scientific attainment. Any discussion of morbid conditions, therefore, that does not embrace etiology is superficial and inadequate; any employment of remedy that does not regard causative factor first and materia medica second must be rated as haphazard and aimless, inasmuch as there can be no acquisition of learning without investigation and no therapeutic advancement without intelligent application of remedy.

The inexorable demand for the study of cause as well as effect has led to specialism in medicine, and particularly to the development of gynecology. It was this that created another department of the Healing Art within a single generation. Symptomatology without etiology, therefore, now passes at a discount; hence the critical examination before application of the proper remedy, not always a drug.

Before the advent of physical examination, and through all the antecedent ages of woman's history, gynecology was in a state of non-development; there was no adequate light upon the subject, and progress was dependent wholly upon accident. The invention of Sims' speculum marked the beginning of gynecological science, for not until that time was the requisite knowledge accessible for rational treatment. Anterior to that, surgical intervention as a recognized and imperative agency in the cure of many of the ailments of woman had no place. Beyond the employment of supports of various kinds for uterine displacements, little was done in a surgical way to restore the invalid woman to her normal physical status.

In this I do not forget the wonderful achievements of McDowell and others in abdominal surgery, then in its infancy; nor the tentative efforts here and there made to strengthen the torn perineum. I claim simply that gynecology as a science did not have growth until Sims answered the demand for physical examination; that the technique of gynecology dates from that time, and that surgery as an obvious neces-

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sity in the gynecological therapeutics was then recognized and established.

Gynecology without surgery would almost resemble literature without an alphabet—it would certainly be a creation without its essential part. For surgery is an indispensable factor in the female equation, inasmuch as many of the physical problems of woman can not be solved without it.

Gynecological surgery has come to stay. It is here by right of evolution. It is the culmination of developmental process and cannot be hindered or set back by the timid or the stupid. The rapid multiplication of surgeons in recent times has been, it is true, a source of great mental disturbance to many so-called conservative people; but in spite of their fears and their aspersions about surgeons of base mercenary motive and of unworthy desire "to cut, regardless," the demand for surgeons has not been equalled by the supply. The actual need of surgical help has never been met and cannot be met on the large scale, in the very nature of things, for a long time to come; and I measure well my words. Grant the errors of omission and commission—the mistakes and faulty technique—of the tyro surgeon, and you have but admitted the costs of tuition—the necessary experience of all culture. You have in nowise disproved the necessity for good surgery in multi-millions of cases.

The phenomenal development of surgery in our time is not a human fiction, but the answer to an imperative call; it is the response of the enlightened to the necessitous demands of human need. And it is a matter of education. Both the operator and the operated are learning. While surgeons require the utmost qualification for their great service—and I point with satisfaction to the large number of our profession who have already mastered the knowledge, both of head and hand, necessary to successful surgery—the people everywhere—I mean the patients, their guardians and their physicians—all of them, require education quite as much in their way to be made intelligent concerning the necessity of early surgical procedure. The greatest lesson in the life-school to-day is to know when the inevitable surgical operation will be the most opportune; is to be able to detect the surgical malady in its very earliest history and to have education enough to decide upon radical treatment at a date sufficiently near the beginning to insure complete restoration to health. The standing blot upon the enlightenment of to-day is the lethargy that holds the candidate for surgery back until his opportunity has gone by forever—until surgery can no longer be efficient to save.

Let us look for a moment at the so-called "conservative" people; those who have viewed with alarm, for instance, what they call an in-

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vasion of the sacred privacy of the female sexual domain and have strenuously opposed not only all physical examination, but, also, all suggestion of surgical remedy. Laymen have objected and have said, times without number, "Before I submit, I will die first," and then proceeded to die; and uneducated and unprincipled physicians everywhere have catered to such destitution of knowledge by advertising in their several ways their ability "to cure without the knife." To dispel such crass ignorance and to lay bare such professional incompetency—if I am justified in using a term so far below the requirement—has been and is an herculean task. But the work has progressed and the task is being accomplished. More and more, as experience broadens are the people of the world learning the lesson of their greatest good; more and more, as they are confronted by the awful catastrophes, the deaths due solely to delay, are they coming to realize the inestimable value of saved opportunity. Such unfortunates have learned too late that their true professional adviser was not he who weakly or wickedly counseled the do-nothing or "no-knife" policy till the day of salvation was passed; but the one who told them the unvarnished truth about their condition, however unpalatable that proved to be, and who courageously proposed to aid them to the extent of his ability in the removal of the causation of the difficulty. It is becoming known, thank God, that conservatism is the thing that conserves; and is not the ignorant and vicious shilly-shally that allows a patient to drift beyond the breakers into unknown depths where calamity is unavoidable.

The Creator said at the beginning, "Let there be light;" and light from that day to this has continued to penetrate. Happy incident is it for the afflicted woman if light shall dawn upon her problem at the opportune time; if the brave and true suggestion can reach her before it is everlastingly too late, and while yet her difficulty is at the minimum! And this, too, she extends to the race. All life is but an education; it is but the dispersion of ignorance.

It is not a double decade since surgeons were called to operate upon enormously large abdominal tumors only; where it was a question often whether the tumor should be removed from the woman or the woman from the tumor. Such women had been bed-ridden for protracted periods, all expectant treatment had long since ceased, and the surgical operation was the last resort—inasmuch as it "was death anyway." Is it any surprise that the percentage of loss was 60 per cent and that surgery was regarded as an extra-hazardous procedure?

To-day such belated individuals are hard to find. It is very rare that one comes straggling in. Only once in a great while is a surgeon now called upon to remove a mammoth tumor. Why? Because everybody has learned better. When surgeons make records of cures of from 98

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to 99½ per cent by operating upon small tumors, the laity realizes that early operations are the safer, and act accordingly.

This is typical and illustrative of my point. Truth has general applicability. A half decade ago we were contending against expectant treatment of appendicitis. Men were still advocating cathartics and oil-treatment and general expectancy, both in early and late appendicitis; and some were called butchers and charged with being crazed by their inordinate desire to make an early "cut." To-day we camp on different ground. The expectationists, the most of them, have had an accession of information in five years, and now know that they can not be absolutely sure of their diagnosis in what has come to be known as the storm-center of the abdomen; that several other morbid processes obtain in that region that are so closely allied in their symptoms to appendicitis as to deceive the very elect; that differentiation in many cases can not be made without an exploratory operation, and that expectant treatment under such circumstances may be homicidal. More than that, without an exploratory, they can not know, in the appendix case proper, the exact status of the morbidity; or whether perforation has already occurred, or gangrene is established and progressive, or general suppurative peritonitis is being engendered. The intelligent adviser to-day does not wait long for things to evolve in a supposed case of appendicitis, particularly when progress by the hour does not appear to be in the right direction.

The wide-awake doctor, in supposed appendicitis, no longer does much waiting for things to turn up, or in some haphazard way to evolve for the good, when ignorance of the true condition is the most prominent factor in the doctor's equation, and certainty as to the situation is out of the question. Experience has proved that opportune surgery will clear up a diagnosis and save the appendix case, or its analogue; and that opportunity means the appendix before the perforation or gangrene. It means appendicectomy in the early hours of the difficulty.

The rattlesnake always warns its victim; Mont Pelee boiled his bituminous cauldron and vomited death long enough before May eighth to enable every one to reach safety; and every appendix case or its double has a history of warning sufficiently ample to enable every victim to utilize his opportunity. It was too late at St. Pierre when they commenced to run!

The history of surgical progress teaches that advancement is made by the anticipation of events. The percentage of cures is enhanced by early intervention; and the trend of all surgical experience dictates that the best time to avert catastrophe is before the dread event is actually upon you.

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As a consequence, desperate surgery is to-day less and less required; and minor surgery is more and more in evidence. Anticipating the later necessity, under perhaps then forbidding circumstances, it is a matter of election in every wisely conducted case—I mean it is a matter of choice—both as to the time and the place of the operation and as to the good operator. Thus it is, through wise anticipation, that minor or easy surgery is becoming in our time the major part of the practice; and that the terrors of the "knife" are being removed from the surgeon and relegated to the doctor or patient who has been responsible for the fatal procrastination.

The evolution of surgery is toward prophylaxis; from the desperate to the less desperate; from the dangerous to the entirely safe; from the corrective to the preventive.

The relation of surgery to gynecology is two-fold, it is first, to effect the removal of the gross obstacles that impede the woman's health; and second, it is to anticipate all embarrassments of functional activity that surely will end in degenerations and neoplasms with which the surgeon will have to deal inevitably.

Beginning with the girl not later than puberty, surgery will see to it that menstrual embarrassments shall have abatement through removal of every physical irritant, either clitorial or rectal, as well as every mechanical interference; so that hygiene and medicinal remedy, if called for, shall have unimpeded action. It is the province of surgery to see to it that every marriageable, or to be married, girl is physically capable of motherhood; that she is not the victim of an infantile uterus or other functional impediment—and that she is in prime condition to do a woman's work in the world without catastrophe. Surgery will closely follow the parturient act with the repair of all lacerations and the removal of all rectal and vesical morbidity engendered by the pelvic plethora of gestation—for rectum and bladder are also under the care of the gynecologist. It will discountenance long-continued tampon or pessary treatment for uterine retro-displacements and prolapses when ventro-suspension is the only logical procedure. It will do conservative patch-work upon ovaries and tubes and save them from major degenerations that will surely demand their extirpation. It will look intently at every corrosive ulceration of os or cervix uteri, regard with alarm every hemorrhagic uterine discharge at or after the menopause; and refuse to make long question concerning the true nature of "lumps" in the breast. The uterine cervix with cancer just started demands immediate extirpation of the whole organ with its adnexa. The "change-of-life" hemorrhage signifies either intra-uterine vegetations, fibroid tumor or corporeal cancer, and should have the sharp curette immediately, and, this failing, removal of the fibroid, or

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pan-hysterectomy without delay. Every nodule in the mammae is under indictment; it is either malignant or benign—presumably malignant. Surgery will give her the benefit of the doubt, but will not wait long. If there is no doubt of cancer on the morning of the discovery, the only safety requires extirpation of the entire breast before noon, or despatch similar thereto, together with all the axillary glands of that side. Do not dally with cancer if you would be spared wide-spread proliferation of cancer cells; if you would operate while you still have a boundary; if you would get there in time to save.

The relation of surgery to gynecology is in the first place that of the conservative; it is the speeding horseman down the valley, shouting "The dam is breaking, get out of the way!" It is the prevention of all that is implied by the words desperate surgery! In the second place, the relation is that of the radical; the catastrophe has been permitted; the wreck has occurred in part or in whole; and surgery is called in to verify the hopelessness of the situation or to clear away the debris and to make possible the prolongation of a badly crippled existence.

Surgery is not only supplemental but complemental to gynecology. In many cases, in fact, it covers the entire field and serves the whole purpose. It is never inimical to the "indicated remedy," but, on the contrary, may save that valiant arm of our service in untold instances from failure and ignominious defeat. What can be less lustrous than a prescription that has no relevancy to the case in hand; than the exhibition of an internal remedy that must be powerless to effect any change in the physical condition of the patient?

Every competent workman has tools for specific purposes, and makes exhibition of his masterful workmanship by putting those tools to their intended use. He may get through a pinch by the use of substitutes; but would never choose to do so willingly. The same is true of the physician's armamentarium. The most acceptable and generally satisfactory service is rendered by the employment of that measure, or remedy, best suited to the accomplishment of the end sought. It does not matter whether that end can be attained in some other way—by internal remedy alone, if you please, rather than by the surgical remedy, single or combined; the *desideratum* is to secure the most advantageous result.

The practice of medicine—and that includes the possible use of everything that can under any circumstances be curative of disease or physical embarrassment—requires the widest exercise possible of what is known as *common sense*. This will demand the employment of the surgical remedy very often where the Fathers, in similar cases, made use of the internal remedy alone.

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DISCUSSION:

J. M. LEE, M. D.: I received a copy of Dr. Runnel's excellent paper but ten days ago. I read it over carefully, but have prepared no discussion. I will not discuss it, but I am going to endorse every word of it.

I only want to say one word with reference to cancer, and another with reference to appendicitis. Whenever you get a patient with a nodule in the breast, do not let her go three months, six to the outside, before you operate or bring the case to the attention of the surgeon. Some of you are not doing this. It is a fact that many of us are not working up to our privileges. We must, in future, if we would do the best for those who suffer from this terrible disease, bring them to operation speedily, and give them the only chance which they have for life. I know that there are many remedies of late brought to the attention of the physician to be used chiefly as hypodermic injections. There is not one of them that is worth while to use in operable cases, and if you waste valuable time in their employment the patient must die. If, on the other hand, you have a patient who is inoperable, whose disease has gone to a point where you can do nothing for it except to use these remedies, then do so; but in all cases send them to the surgeon early or operate yourself.

How are we going to know when to operate in cases of appendicitis? Every time that you get a case and there is fever, you may assume that pus is present, or something worse, and have that patient operated upon immediately. This is a bold position to take, isn't it? Yes, I know it is, but we are prepared to sustain that position, and I challenge any man to show before us to-day that it is not the only safe course.

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THE UTERINE REFLEXES—THEIR FACTS, FACTITIONS AND FICTITIONS

E. R. EGGLESTON, M. D.
MT. VERNON, O.

The first considerations are those of anatomy and physiology. The facts of these become the basis of all that may follow after them, whether semiological or pathological. For if the distinctions we start out with are to become assurances, no suppositions or assumptions are to be admitted within the lines of argument; and, therefore, all the more do they stand as fixed standards. The origin of nerve tracts, then, their classification, their distribution and their relations are the points of beginning; their functions, as manifested in the multiplied activities of the body, as sensation, motion, nutrition and numerous special operations, are the next points of interest; while the rigid or lax delimitation of the fields of function, the facts or possibilities of over-lapping of such fields, or actual transfer of the circulating forces by means of induction, collateral channels, or by some omniscient central distributing agency, are the later points, and those with which we have chiefly to deal.

Under such circumstances definitions become of considerable importance, and equally so to abide by them.

First, then, a *reflex* is the transmission of a stimulus from one given point to another having functional relations with it, to subserve the operations of the organs within the given circuit. The tract pursued by sensory stimuli, the centers that receive and transmit, and the tract that returns responsive impulses are always the same, each for its own kind. None of the tracts may be substituted one for the other. No system is capable of reproducing the action of another. There are no vicarious reflex actions.

A *reflex center* is, according to Bramwell:

"1. A point *from* which voluntary motor, reflex-motor, vaso-motor, and trophic influences are distributed *to;* and *to which* peripheral impressions, producing reflex movements and sensations, proceed from a limited area of the body.

"2. A *conducting medium* through which the great tracts, motor sensory, controlling, etc., pass, which place the brain in connection with all the other segments situated below it."

A center is therefore composite. Through it the response to given sensory stimulation may be either motion, voluntary or reflex; vaso-

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motor—constrictor, dilator, or inhibitory; or trophic. Thus voluntary and involuntary motion, sensation, conditions of circulation and nutrition are all open to modification by the simple reflex operating through composite centers. But this fact always obtains: No specific stimulus ever pursues a course to a center over other than its own prescribed tract; and no response to it ever returns over other than that marked out for it; and no other than its own kind ever traverses either. That is to say, if an organ is the field of distribution for motor, sensory, vaso-motor and trophic nerves, and has a center of supply which is also its reflex center, it is *to* this that all stimuli of whatever kind are sent, and *from* it that all impulses are returned, always to and from through the same channels; because such is their function and no other; because anatomical and physiological necessities have placed them there for such definite purposes. Vaso-motor and thermal or other transmissions are not interchangeable either as stimuli or returned impulses; nor are these interchangeable with motor and sensory actions, nor they with each other.

This is true of every system of nerves, cerebro-spinal, sympathetic, trophic, and vaso-motor—true of them *as systems*. But while it is true that there can be no substitution of the function of any one for the function of any other, it is still the fact that the dissociation is not so complete as it appears to be. For not only are the systems bound together by links essential to the dissemination of stimuli, returning impulses, co-ordination and inhibition, such diffusive power being essential to the well-being of the whole, but they are also in every direction under the controlling or modifying influence of the highest, the cerebral centers.

A *reyex arc* is composed of the channel which conveys stimuli to a center, the center itself, and the tract by which responsive impulses are returned. The mechanism is intrinsically essential, and is invariable. It is complete if a complete reflex traverses the circuit; if incomplete no reflex can by any possibility traverse it. It is never completed by vicarious intervention from other reflex systems. They are all, in an anatomical and physiological sense, strictly systematic. Therefore a nervous manifestation can never be said to be reflex unless at the same time it can be shown to complete a reflex arc.

Thus there is more and more forced into prominence the fact that in normal conditions each system is fully equipped to carry on its systematic operations, and does it, without supplementary forces drawn from any other or even from the brain itself. But it may be supposed that pathological conditions may break into this arrangement. If they do it may well be questioned whether results are only those of confusion, or are revolutionary; are irresponsible to any principle involved, or

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are obscurely maintained according to type, or fully perverted. These are the problems to be solved.

On a basis of this kind, from which there appears to be no appeal, it is easy to believe that, except for the exercise of close observation, the facts of reflex action may be misinterpreted. Faulty interpretation may refer to symptoms so similar to true reflexes, but still untrue, as to make deception easy; that is, they are *fictitious reflexes.* Or, the symptoms may have no real resemblance, being only associated, or obscure or otherwise unexplainable, and are, therefore, *fictitious reflexes.* Or they may not occur in organs associated along the same nerve-tract, again fictitious. Or new pathological processes may intervene along the courses of reflex arcs, which introduce similar but new orders of events, giving rise to both factitious and fictitious reflexes.

These points are well shown in some typical examples.

Among the so-called uterine reflex symptoms the nausea and vomiting of pregnancy is perhaps the most conspicuous and familiar. There is, certainly, a coincident cause and result, but the belief commonly entertained that it is a reflex from and on account of the gravid uterus is a mistake, unless we grant the existence of secondary reflexes, or relays, which is problematical. It is the irritative expression of over-development, and operates through the developmental systems according to the nature of things, primarily through the sympathetic system, because it exclusively contracts the whole visceral nutrient mechanism; secondarily through the stomach, because it is the chief organ in the mechanism; and, lastly, upon the vomiting center in the medulla, a reflex from gastric irritation, and no more. Such coincidences as mammary quickening and growth—which, by the way, are not "sympathetic" effects of uterine conditions—and added amplitude of the body must be considered as of the same character, having the same causes and in every way contributing to the same effects—even reflex effects in so far as they occur. This is so clearly the fact that it is fair to say that were an exact balance between the growing uterus and child, and mammary and other developmentary proceedings on one hand, and the nutrient operations on the other, maintained, there would be no ovewhelming rush of force to the centers of development, and therefore no disturbance of equilibrium, and therefore no nausea.

This case, you will remember, is physiological, and is therefore a type. You will also remember that "pathology is no more than sick physiology," and that its manifestations are for that reason modeled after physiological types—true in pulmonary, cardiac, nephritic, or nervous diseases, as such, and as true to type, as in uterine diseases as a class, or in pregnancy. Therefore some very significant generalizations become prominent here. The fact that the reproductive system

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stands as the highest manifestation of reproductive energy within the body furnishes the most unimpeachable testimony that diseases of this system will be shown by signs of reproductive disorder—as general as well as special nutrition disturbances. The conditions of pregnancy are clear examples of it; the general nervous weakness and irritability, and therefore excessive nerve-waste, and therefore nutrition degeneracy so common to uterine diseases of chronic type—at the same time so prolific of so-called reflexes—are also clear examples of it. As a matter of course the suffering in any organic range expresses itself according to its organic habit. But these are not reflexes; they are characteristic symptoms of suffering of a system—characteristic because it is a system, and because it has no other way to manifest its suffering. These symptoms are, doubtless, many of them reflex—must be, in fact; but that they are so widespread and so obviously irresponsible to the plainest physiological principles as we are led to believe, cannot be justified by the facts.

Another case, the heart. The automatic cardiac mechanism is an extremely interesting arrangement. Here, as in other cases, all conditions not within the ability of the automatic apparatus are under control of cerebral—probably basal—centers, and are brought into play through ordinary cardio-systematic reflex channels. Motor power is resident within the organ itself, in the automatic ganglia. Motion is modified by acceleratory fibers from the vagus, but so far as has been demonstrated no spinal fibers make their way into it. It is further supplied from all divisions of the vaso-motor system, and with nutrient fibers from the sympathetic which also reach it through the vagus.

The point begins to appear to you, that the heart, because of its position at the center of the circulatory systems where all the primary forces concerned in the conservation of the body meet on convergent lines, is itself conserved by constrictive protection against all forms of reflected stimulation which flow through ordinary channels in the spinal cord. It is not within the radius of the more ordinary systematic reflex arcs. It is not within at least the ordinary reflex tracts of the cord, which is the universal and exclusive seat of such centers, without which reflex action in any definable sense is impossible. Its actions and reactions are mainly automatic, and its reflexes systematic. Thus, according to the teaching of both anatomy and physiology, so-called symptoms of uterine irritation reflected upon the heart become impossible. There are no channels through which such reflexes may reach it. It forms no part of, nor is it associated along the course of any uterine reflex arc.

And so I might go on through system after system, urinary, intestinal, pulmonary, and even the cerebral systems of special senses, always

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finding in the end that the real reflexes are characteristic of the individualized functions of which they form so important a part, and of no other, and are uniformly of like kind with the normal function of the organ or system involved. It is also found that it is the systems and not the reflex arcs that are so prodigal of symptoms, those capable of dissemination and therefore not individualized. The more highly differential the system—as of vision, or heart-beat, or uterine distress, or rectal spasm—the more nearly it simulates, or is, reflex; the more capable of dissemination or duplication in other systems, as in gastric, or urinary, or vaso-motor, the more nearly it simulates, or is, systematic.

At this point it is essential that another condition be noted, and the more so since it rationally explains so much of what is known as the dissemination or transfer of reflexes. The setting up of new pathological centers, secondary or original, which implicate either arm or center of a reflex circuit, necessarily modify or inhibit or destroy the identity of such circuits. They are no longer reflex circuits because no return impulse can be made. Now if the sensory side and center of the arc are intact, returning impulse impossible, a new channel for return in kind is sought for, which again impossible, the sensory stimulant is lost by dissemination among other systems, or makes return of unlike kind and therefore spurious or fictitious. But there is a distinction to be made in the character of the symptoms evoked by this new disease center, which is based upon the fact in neural pathology that in system diseases there occur irritations or degenerations of nerve fibers, which, from the point of injury or disease, extend outward along nerve tracts to their distal extremities, or inward to their centers of origin, according as their function operates in one direction or the other. For example, motor degenerations progress downward, or toward the periphery; while sensory degenerations progress upward or toward the center. The location and character of the symptoms of these cases are therefore unlike, lesion apparently the same, and their interpretation must be sought for in the characteristics of the systems involved, whether motor or sensory. It is to be presumed that many of the pains of uterine disease that are referred to other parts of the body are of this secondary character; therefore systematic and not reflex.

And now I hazard an opinion on the type and character of this large class of symptoms. They are neurotic, of inflammatory type, not necessarily but frequently degenerative. Paresis of filaments or small groups of nerves, failure along lines of nutritive reproduction, and incurability except through the slow process of regeneration, are prominent features. This group of conditions, not infrequent as a group, is a basis of the succeeding invalidism of the large number of cases which, undergoing operations, do not get well; and it is yet to be recognized

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as a most responsible factor in recurrences, whether of growths or otherwise, which are sought to be overcome by operative measures only. Chronic cases of uterine disease frequently present such a symptomatological scheme as this: (a) undoubted pelvic diseases, including reflexes referred to the organs themselves; (b) systematic manifestations—no system exempted, showing cause of consequence of pelvic derangement; (c) localized or more widely distributed neuritis, the result of operations, mechanical interference, irritating local medication, with in each instance extension of inflammation along lines of continuity. Reflex action explains a few items of such a vast complication, but is almost ridiculously inadequate to explain such a sum total.

The same course of interpretation sheds also a flood of light upon the conditions known as "constitutional." Their physiological standing undemonstrated, it is easy to invoke their ubiquity. But the common fact is that they cannot be shown to be either temperamental, or hereditary, or diathetic, or cachectic; but it can be that they are neuro-inflammatory, or trophic, or sympathetic, or vaso-motor, or nutritional—that is, certain of these systems have failed, and failing have involved the whole. Therefore they also are systematic and not constitutional.

Discussion:

W. B. Carpenter, M. D.: It seems to me, Mr. Chairman, that the Doctor has given us a thoughtful and timely paper upon an important subject. It is undoubtedly necessary that more "gray matter" should be used in the study of the facts connected with this branch of nerve-action. The more information one has, the less likely he will be to attribute every chronic ailment in women to serious pelvic—especially uterine—disorder; and the more likely will he be to realize that serious disorder may have been engendered by some systemic disturbance central elsewhere. The study of nerve-reflex in health and disease is bewitchingly entertaining and thoroughly instructive. The subject of the paper introduces us principally to the action of the so-called sympathetic nervous system, though I am very much inclined to the belief that this and the cerebro-spinal system are essentially the same—two parts of one great whole, with different arrangement of gray matter and white matter and nerve-center to subserve the necessities of two distinct classes of functions. The sympathetic system is charged with the duty of building and repairing the body; and in reaching every part of the organism its filaments carry fibres of the other great nerve-system, so that every cell of every organ is in direct relation with every other, and also with the great centers and with the outside world. It seems to me that in a state of health every organ is constantly sending messages of cheer and satisfaction to every other, and is constantly receiving such in reply. This is normal life, in which I take it that every part has upon every other part a genuine reflex influence, which is "the transmission of a stimulus from one given point to another having functional relations with it." It is hard for me to see how an organ can escape

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functional relation with every other organ when the anatomical distribution of the sympathetic nerve filaments is as it is. And when we think of how nearly every filament of this sympathetic nerve is bound into a small bundle or cord, with one or more filaments of the other great system of nerves, it seems as though there were formed many arcs in every direction which not only might be, but are, the tracts of nerve-influence, direct or reflex, as circumstance may determine.

Turning, now, to the organ referred to by the essayist, we admit that when physiology is undisturbed there can be no consciousness either of its existence or of any influence upon any other part of the body; but when physiology becomes pathology the case is different. Being a part of the tubular system of the general organism, and being composed of involuntary muscular fibres, it is under the control of the sympathetic nervous system. A pathologic condition here usually means hyperemia or congestion, when the nerves not only send word to the *ego* through the communicating cerebro-spinal filaments, establishing the sensation of local pain, weight or discomfort, but also through its own numerous fibres and ganglia manages to let all other organs know of the embarrassment—the most likely result of all this commotion being, to say the least, nutritional and vaso-motor disturbances in some or all directions—being a true uterine reflex, a *consequent* of all its trouble. The nausea and vomiting of pregnancy are undoubted uterine reflexes; that condition is truly a physiological one, and when so, no painful or "sick" symptoms are experienced; but when nutritional equilibrium is disturbed by any cause, pathologic symptoms obtain, the irritation from which, through the sympathetic nerves to the ganglia of the stomach and medulla, result in the nausea and vomiting more or less severe. That the heart may show reflex symptoms from uterine disease seems not only possible, but is the undoubted experience of all investigators. The sympathetic nervous system is in direct communication with whole organs through many nerve-cords and ganglia; the vaso-motor system reaches both, and then as the heart receives some filaments from the cervical spine (See Gray's Anatomy), it would seem that uterine disease could disarrange the heart's action whether through such an arc as was referred to by the essayist, or through the direct agency of the ganglionic nervous system. So, every organ in the body, even the brain itself, may receive the evil influence of uterine disorder, and show a genuine uterine reflex—not always the same symptoms that would be sent back to the organ itself by a center to which the afferent message had gone, but abnormal conditions set up through the agency of the composite centers along the many lines reaching them.

Thus far I have tried to touch on the facts of uterine reflexes. These facts are factitious, as says the essayist, when they are wrongly interpreted, and this is not the fault of the reflex itself. Many times the correct reading is only reached by a process of exclusion after a careful study of the case in all its bearings. These facts are fictitious, too, when they are not the first cause of the troubles under investigation, being secondary to disturbances elsewhere; or, as says the paper, when associated with other organic trouble along the same nerve-tract. You know that the nerves of the sympathetic system always give the same response in whole or in part to the same stimulus so long as they are in

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health; and in abnormal or diseased conditions of the organism it is easy to see how an entirely fictitious state of affairs can exist with reference to some particular organ. What Dr. Pratt calls the "Scattered Brain" of the sympathetic system will account for the fact that each organ or system is more or less of a law unto itself, still closely bound to and working in harmony with every other part of the whole organism, and producing sad discord when itself becomes out of tune. Just how these influences are impressed here and there, we cannot discuss now. I am glad the essayist spoke of the neuro-inflammatory conditions as being important causative factors. That will certainly account for much of the continually increasing and spreading local trouble, and for the continuance of severe ailments after the offending organs have been removed. But so many thoughts come up that we cannot touch on all. Much study of these subjects will not only serve to make us better informed as to nerve action, direct and reflex, but will lead us to appreciate more fully than ever how, in treatment, wonderful results can be expected from the proper application of our beneficent homœopathic law.

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LIMITATIONS OF THERAPEUTICS IN GYNECOLOGY

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INTRODUCTION.—The thoughtful medical attendant, in making a survey of any particular case, gynecological or some other, takes into consideration at least two conditions. One is the status of the patient as a whole, the other the possibilities that reside in remedies. The invoice of the patient includes the pathological condition, the state of vitality, an estimate of recuperative capacity, and contributing agencies toward further decline or toward improvement. With reference to remedies, the survey should be with regard to all known remedial agents that may be suggested by the morbid anatomy and symptomatology, ability to be guided by former successes and failures under like circumstances, and, above all, each particular case should be regarded as an individual entity calling for its special treatment and its closest *similimum*. In other words, ultimate success or failure depends upon whether foresight discriminates what is curable with remedies, points out when or where operative measures must be summoned, and what results either will be apt to yield.

Probably one-half of the cases in gynecology that are along the border-line of medicine and surgery are spoiled for want of discrimination, by indifferent and careless routineism, or by the doctor being an extremist, over-estimating on the one hand and underestimating upon the other, the reasonable returns from either therapeutical or operative procedure. No profession or occupation requires a more discerning and impartial judgment than that of the gynecological physician and surgeon. Ability to see the pivotal point in time and condition requires sagacity and wisdom. The making of a diagnosis, which is so very important, is not, by any means, the limitation of judgment.

CLASSIFICATION.—The old division of diseases into two groups, functional and organic, is, many times, a great clinical convenience in deciding upon what course to pursue. If one can keep this distinction clearly in mind, he is often aided, materially, in deciding upon a line of procedure and will not always be in a state of uncertainty as to whether medical treatment alone, operative treatment alone, or a mixed treatment should be advised and can be pursued to a satisfactory termination. The principal hope of internal medication is mostly in the domain of functional diseases. The sphere of the operator is principally in the organic group. That is to say, the hope of medical cure depends,

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to a very great degree, upon whether the disease be functional; the necessity of surgical interference depends upon whether it be organic.

This leads to the consideration of palliatives. We may assume, I suppose, that every gynecological condition, although it be organic, that the operator turns from and pronounces to be inoperable, to be a medical case—an incurable, of course—still looking to therapy for a crutch upon which it may hobble as painlessly as possible out of the world. As a general proposition, we agree that the indicated remedy is the remedy, still none of us would be deaf to the cry of constant pain. All of us would at the last, and perhaps some at first, resort to pain-easing drugs. Since the number of palliatives is constantly increasing, since the habit of using poly-pharmic combinations has become fixed with a large class of our prescribers, and, especially, since operative procedure has done so much in correcting organic defects, a tendency to invoke these measures unduly in purely functional conditions, when judicious medication would produce better results, is increasing, a crime not by any means peculiar to gynecologists.

The following is the summing up of an exhaustive old-school discussion of medical diseases of women. "Simply regulate the various functions of the body so far as may be possible or necessary in order to maintain as nearly as practicable a physiological condition, and then relieve pain or other disturbing symptoms that may arise." This thesis sounds well and it is safe to say that the means that would be employed by the one who gave it utterance would not be different from those of our school who are more familiar with chloral hydrate, morphine, sulphonal and bromides than they are with materia medica.

In routine practice, a clear distinction between what will cure and what will merely palliate is often lost or confused. The dulling of the sense of judgment in this regard is the first evidence of retrogression; the loss of exercise of such judgment is evidence of total loss of the higher therapeutic sense or instinct.

Necessity for Clear Etiological Discrimination.—To illustrate the necessity for clear discrimination, suppose we consider a young female who becomes an epileptic. The first thought with some would be to perform some kind of an operation upon her genitalia, as many cases are reported to have been cured by operative measures. Suppose the results of operation to be negative, as operations often are, and the patient comes back to her former habits. It may be that she is a neurotic from birth. Her father may have been a drunkard or in some other way depraved; her mother may have been a woman of easy virtue or guilty of other personal crime. Would it not be a short-sighted estimate of her case that disregards her congenital impulse? Or, suppose we turn to medicine; what can it promise her? A cure? Like operation, it might

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be "tried" and, like it, might fail. Both physician and surgeon fail to make her right. She is outside the limits of all kinds and methods of permanent cure. She is doomed from conception to bear the mark of degeneracy. Of all the council taken in her case, he alone is right who comprehends the limitations of therapeutics, surgery, hygiene, moral suasion, education and social surroundings from the first, and prognoses accordingly. Of course, to such a one we would deny all the means of physical or medicinal grace, but would anticipate some delinquency to super-abound over them. Who has not had uncomfortable experiences in such and similar cases? I believe that many habits evidencing transmitted peculiarities belong to this class. They must be discriminated, in holding out promises for betterment, from the acquired perversions that may be cured by simply removing irritating tissue or by a "course in medicine." Instance many failures to relieve by adjusting spectacles, circumcision, orificial "work," or the indicated remedy. Oculist, aurist, orificialist, gynecologist, neurologist, therapeutist sometimes must go down in the slump together and only he is entitled to wave the banner over them upon the folds of which are emblazoned the words, "I told you so," who, from the first, saw that the infinity of disease exceeds the narrow bounds of medical and surgical art and science.

COMPENSATION.—It often happens as the result of parturition that lasting violence is done to the tissues and passages involved in the act, that as a result of severe illness or simple exhaustion relaxations and displacements follow, or in some other way organic changes are acquired or inflicted. No doubt but that many women go about with reasonable comfort who bear the defects of severe laceration. Others with prolapses or displacements either recover or bear the defect without suffering. Often such cases respond to medication in a general way and are greatly benefited. Not that the lacerations unite, or cicatrices are removed, or adhesions disappear, or bound-down organs again ride freely in their natural positions as a result of taking medicine. But a kind of compensation can sometimes be established upon the part of other tissues. They come to reinforce or share the burden in some ways of the defective organs. Nobody, I presume, would argue that an organic valvular deformity in the heart is likely to become the same as at first, or that the valve will ever cease to leak. But the other parts of the organ, by hypertrophy, can compensate for the defect. The general condition of the body can be put in the best working order, and by obviating irregularities in other parts the system may bear the lesion in question conveniently. The same may be done in some of the organic diseases of women. By maintaining the general tone of the system, by giving attention to the condition of adjacent parts, it often comes about that an organic disease does not require resort to surgical expedients. Con-

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tributing to this dsired end, the proper remedy is absolutely necessary, and with it, properly applied, many women are spared the necessity of what they usually regard as more severe ordeals.

BOYS AND GIRLS.—I do not suppose that any one here would challenge the statement that, as a class, boys are more vigorous than girls. But why are they? This question, while it may encroach in one extreme upon hygiene, and in the other upon pediatrics, lies clearly inside the scope of medical diseases of women. The solution of the problem would brighten the practice of both preventive and applied medicine. So diverse are our notions and theories upon this point, if every one here were to put forth his explanation he would find somebody to differ with him.

However, there are some features of the problem upon which a pretty general agreement might be made. In the first place, boys and girls have the same initial start in life, being born into the same environment; and because they have the same fathers and mothers, heredity can not be appealed to in explanation of the difference in physical and constitutional endurance. I am speaking now of children before the dawn of puberty, for puberty should come upon both sexes, if the childhood have been normal, naturally and pleasantly. Mothers frequently make the statement that their daughters are delicate but their sons appear strong and robust. The medical adviser is apt to reply to this: "You know that neither you nor your mother were very strong; it is hereditary." Heredity can be relied upon to bear innumerable burdens and to furnish excuses for many weaknesses of flesh and spirit, but not in this case. Why are not the debilities of the grandmother and mother transmitted to the sons as well as the daughters? Heredity accounts for all the children in a family being alike, not unlike. It will not explain the conditions. Physiological and other natural causes will not entirely explain why girls are frequently taking calcarea, senechio, pulsatilla, arsenicum, ferrum, belladonna, cactus, and probably cod-liver oil and "tonics." The causes are not congenital or natural, they are artificial and of such a character that the boys are largely exempt from them. Otherwise, the boys would require "treatment" as much as the girls. The daughters are not born with less proportionate vital capacity, or endurance for performing the legitimate functions of life, than the sons.

Legitimately, the gynecologist should be as much a stranger to a woman's first twenty years of life as an obstetrician, and his coming across her pathway at any time should not be until after she has had a child. The bearing of this is not that the gynecologist is out of place during a woman's early life under the circumstances, but that causes not altogether accounted for by heredity and other processes of nature make him necessary. It is not very often that a physician prescribes for a boy purely on account of his sex, although circumcision is very gen-

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erally practiced. But frequently he must prescribe for the girl because she is predisposed artificially to ailments which the boy escapes. There is no doubt, as society is organized, that physical development of girls is more artificial than that of boys. This artificiality begins about school age. We would, therefore, say that the time when a woman's risk of becoming a medical case in diseases peculiar to her sex commences with, and increases annually after, the sixth year. If environment continues to hold in check her natural development, or medication fails to restore weakened vitality, she is liable to become a gynæcological case, in the popularly accepted sense of the term, at the age of puberty. Girls and young women are more frequent visitors at doctors' offices than boys and young men up to the gonorrhoeal age, and aside from venereal diseases, consult very much more frequently than youths for minor operations.

A girl who is well nourished, correctly trained physically and educated morally, is a good life-insurance risk. When she marries, she will not need the services of a physician, except an obstetrician now and then.

Phases of Life.—There is some advantage in considering in this connection the three phases of female existence; namely, the periods preceding, during and following the child-bearing years. Biologically, the fulfillment of life is the second, the period of reproduction. The first, the period of promise, and the third, the period of fulfillment, are alike in respect that the liability or possibility of menstruation, pregnancy, gestation, parturition, involution and lactation are not to be regarded as liable to come in at any time as complications. The symptoms of the first and last periods are more constant and fixed. The conditions of the period of middle life are naturally varied from gestation to gestation, month to month, even from day to day. The treatment of diseases peculiar to women, apart from the accidents of lying-in and of venereal infection, has comparatively little to do with specific infections. On the contrary, the conditions are usually non-communicable. They arise from perversions of functions due to artificial causes.

Failure of Medicine.—A place where medicines fail ingloriously, as already suggested, is in case of new growths. Compensation and patch-work may assist somewhat in retarding the progressive solution or degeneration of tissues, and in holding things in check for a little time. But when the solution is due to the gnawing of malignant ulceration or the development of new growths, therapeutics, at the best, can only palliate suffering, and for a brief interval reinforce viscera and tissues that must give way sooner or later. The injunction to support nutrition, rest the body, develop the dynamics of the indicated remedy, to the thoughtful physician, should mean to condition such a patient for operation. Operation failing, matters must be fought out in a losing

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conflict upon the battle-ground of palliation and temporary expedients. Sometimes it may have happened that malignancy and degeneration have subsided. So has tuberculosis of the lung spontaneously reacted. But no one will hardly hold out to any particular sufferer that such good fortune is in store for him. The time comes occasionally when the good prescriber, like the picturesque Arabs, with the trained gynecologist, must steal away and let dissolution do its slow but perfect work.

But such defeat, in these present days, is less and less frequent. Skillful diagnostic ability and good judgment seem to be on the increase, while cranky and extreme notions are, fortunately, on the decrease. Before the inoperable stage, anesthetics, antiseptics and the trained gynecologist are invoked. Years of fair health are saved and the patient allowed a more comfortable and less painful taking-off by some acute disease in after life. Whether the limits of therapeutics are widening and keeping up with the operative branches of medicine, there is some doubt.

THE NECESSITY.—It is probably true that provings made upon normal persons are equally useful upon all the organs of both sexes except the sexual organs. It needs no argument to make clear that in diseases peculiar to women provings should necessarily be made upon women. Many women have assisted materially in this valuable department of our therapeutic work. However, there is as much or even more need of revision-proving and provings of new drugs upon women as upon men. This is absolutely necessary if our old scheme of making prescriptions is to be improved. Because a medicine has been "tried," because it has come into use upon clinical evidence entirely, or has been born into the materia medica by some other form of abnormal "presentation," does not add to our medical science. It may be possible, for want of something better, to tolerate it as medical art, but scientific prescribing will not be improved, even if it be not injured, by an unscientific addition to its volume.

DISCUSSION:

J. H. MCCLELLAND, M. D.: I am sorry to say that another engagement has prevented me from hearing anything but the latter part of this paper, and that any discussion I may offer simply arises from a glance at the title of the paper, and I will not detain you very long with anything I may have to say.

There are, of course, limitations to the range of internal therapeutics. No one would attempt to close a perineum, or a lacerated cervix, or any such thing by medication. But there are many things that can be done by means of internal therapeutics. There is no reason in the world, Mr. President, that a uterus, or an ovary should not be affected by medicine, as well as the stomach or the liver. If we have medicines that have been proven clinically or otherwise, we ought to use them

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within certain well-defined limits. Every one knows, every surgeon knows, that cases come to him for the removal of an ovary that can be cured; that the effect of such remedies as *lilium tigrinum, apium virus,* the preparations of *mercury, platina* and *lachesis* have been, over and over again, successful. Patients come suffering from metritis, from enlarged uterus, that can be successfully treated by internal medication. Now, if that be the position taken in the paper, then I agree. I thoroughly believe that we have therapeutic measures which will make unnecessary any operative measure in a great many cases, and that we should not lose sight of this.

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PELVIC PAIN

CHAS. E. WALTON, M. D.
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Pain is the compass of the physician and surgeon pointing to a nerve in distress. To the patient it is the signal of disease, and instigates the call for help. So important is pain as a symptom that time is well spent in learning to interpret its meaning. The click of the telegrapher's intrument is meaningless without the code; the twinges of pain convey no intelligence until we have learned their diagnostic significance. So much of our work has to do with pelvic pain that I invite you to study it with me for a few moments, principally from a clinical standpoint.

Our subject shall embrace the space below the brim of the pelvis. Draw a line from one iliac crest to the other; another line from the lowest border of each tuber ischii; the planes in which these two lines lie will mark the limits of our study. The organs found between these planes are a portion of the small intestines, the sigmoid flexure, the cecum and appendix, the uterus and its appendage; the rectum, the bladder, the prostate gland and a portion of the ureters, the vagina and external organs of generation, the vessels, nerves and lymphatics distributed to these organs, muscles and the fasciæ and peritoneum which line this wonderful region.

This much knowledge of anatomy at least must one possess who would solve the pain problem of the true and false pelvis.

The throbbing pain along the side of the tuber ischii is recognized as indicating an ischio-rectal abscess. The lancinating pain after stool points to a rectal fissure. Rectal soreness, with or without hemorrhage, denotes a pile that the most astute financier never strives to accumulate. The spasmodic clutch of a red-hot pain shows that the mucous membrane of a hollow organ is resenting the carelessness of sitting on a cold surface, even though it be the front doorstep of one's best girl. Cupid and dysentery are nct bosom friends.

The painful closure of the vulvar orifice is the *noli-me-tangere* of a vaginismus. A sense of weight with pain in the back reminds us of a uterus discontented with its normal surroundings striving to demonstrate that a *descensus uteri* and a *descensus averni* are equally *facile*.

A griping pain behind the pubes may mean stone, polypus, enlarged prostate, or cancer of the uterus.

A sore pain over the sigmoid may suggest cancer, syphilis, or tuberculosis.

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A sickening pain in either inguinal region draws our attention to the hernial openings.

A radiating pain above the pubes warns us not to overlook a distended bladder, or a cystitis.

A rhythmical expulsive pain may mean a uterine fibroid, abortion, dysmenorrhea, or impacted feces.

Metritis, endo-metritis; uterine fibroid; hypertrophic uterus; inversion of the uterus; neuralgia of the bladder, uterus or ovary; impacted calculus; sacro-iliac disease; inflammation of ovaries or tubes; pelvic peritonitis, hematocele, or abscess; uterine antero or retro-displacements; subinvolution; ectopic gestation; ulcer of bladder; impacted cecum; appendicitis; anchylosed or fractured coccyx are all associated with pain as a prominent symptom. Nor must we forget the probability of adhesions, if all other causes are eliminated.

In all the above, nothing new has been said, not a single new disease has been mentioned, not a fact recounted that is not familiar to us.

Qui bono? It is for *this*: to emphasize the significance of pain. However familiar we may be with a pronounced symptom we are frequently unacquainted with the associated symptoms which are necessary to make an unerring diagnosis. Many conditions may exist which are not of the usual variety. It is then we are called upon to make a discriminating elimination before we can arrive at an approximate opinion of the exact condition. It is of value to be able to determine what is *not* present. We may say "tumor," but cannot always say of what, or name its variety. We may say "pus," but may not know its origin. We may say "cancer," but not know its exact location. All this is preliminary to a review of the following obscure cases:

Case I.—A lady in excellent health fell backward over a carriage block, causing such severe pain that she thought she had broken her back, overlooking for the moment a Colles' fracture which she had sustained. Pain speedily passed. The fracture was repaired in the usual time. Six weeks later she was taken with violent pain in the right groin. This was followed by chill, fever, and general soreness, which elicited a diagnosis of grippe. She was convalescent in a week, and attended two social functions. Gradually the pain in the groin returned, with occasional chilliness, daily fever and sweat. We thought "pus," and wondered where. We eliminated appendicitis. We found such exquisite pain in the vagina and *cul-de-sac* that a pelvic abscess was suspected. An exploratory incision in the *cul-de-sac* revealed nothing, but relieved the vaginal tenderness. Five days later great tenderness was found beneath the saphenous opening. The probability of a concealed omental hernia was considered and dismissed. The general condition improved, and further operation not considered advisable. At the third visit, some nine days

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later, I found lumbar tenderness, the saphenous tenderness was gone, pus symptoms still predominant. I found a very painful, though small, swelling beneath Poupart's ligament, corresponding in location to the passage of the psoas and iliac muscles over the brim of the pelvis. Extension of the thigh was impossible on account of pain. An incision into the swelling evacuated about two ounces of pus, and permitted extension of the thigh. Nine hours later, sudden pain in the abdomen, great tympanites, temperature dropped below normal, pulse accelerated, death in twenty hours. No *post mortem*. What was the probable condition? From the first the history of the case gave a bias to our diagnosis. There was likely a retro-peritoneal abscess in addition to the one found. Its subsequent rupture terminated the case. So far as the symptom of pain is considered, there might have been an appendicitis, a pelvic abscess or a hernia.

Case II.—An old lady slipped upon an icy pavement and struck upon her back and hip. Great pain followed for weeks. Finally an abdominal swelling in the lumbar region was detected simulating a floating kidney, the pain running through to the back. Nausea and vomiting, chilliness and fever, eventually the increasing swelling and septicemic breath indicated an abscess. No operation was permitted. The day before death there was a large evacuation of very fetid pus per rectum. Post mortem revealed a normal abdominal cavity. Stripping up the peritoneum from the iliac fossa a large pus-cavity was exposed, and three inches of crest of the ilium found to be eroded, due probably to direct injury at the time of the fall, or subsequent inflammation, or both. The significance of this case in relation to our subject is, that persistent pain following an injury indicates a damaged condition of tissues which demands operative interference. An operation would in all probability have saved this patient's life.

Case III.—An old gentleman was taken with a severe pain in the right iliac region, which soon spread to the abdomen and caused profound shock. There was fecal vomiting, indicating obstruction of the bowel, but no tumor, either at hernial opening or in the abdomen. He was dead before I saw him. A *post mortem* showed a very small, lateral, concealed hernia, barely pinched by the internal ring. No inflammation was apparent, and the pinched gut was only a little redder than normal. If so little tissue change caused enough shock to kill the patient, what would an operation have done? And yet that would have given him his only chance for life.

Case IV.—A skillful operator announced to an audience that the next case would be an operation for an abdominal tumor. The patient had been a chronic invalid, complaining of a long-lasting pelvic pain. When the patient was brought in under chloroform the tumor had dis-

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appeared and the operator was greatly disconcerted. An appeal to the audience was made, when it was suggested that in view of the fact that there had been such continuous and long-lasting pain that an incision would be justifiable. It was made, and the ovaries and tubes found to be in such a diseased condition that there was plenty of work to be done. Pelvic pain and skillful operating saved the patient.

Enough has been said to show the significance of pelvic pain both from the standpoint of the pathologist, the clinician, and the operator. It is many times the most valuable symptom, and can seldom be ignored.

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WHY, WHEN AND HOW TO CURETTE

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To some this may seem like too trite a subject, but curettage is really a difficult operation to perform.

By this I mean it is difficult to perform it as it should be. If not properly done, it is not effectual, or it may be even dangerous. Many a woman's life has been sacrificed by reckless or ignorant methods of using the curette. Many more have been permanently injured by such use. Still, many more have not been benefited in the least by the operation. These results have led many physicians to condemn the use of the curette altogether. Many others use it so seldom that they never become adepts in its use. With these facts in mind I wish to give a few ideas about why, when and how to curette. The reasons for using the curette are, that by its use the products of disease, the products of conception, or any foreign substance within the uterus can better be removed by its use than by any other method. As a rule, nature can not do the work successfully unaided. In fact, nature is, sooner or later, completely overpowered, or so seriously handicapped, that the woman becomes a chronic invalid. This being true, it is certainly desirable to adopt some method of treatment that will prevent such untimely results. The proper use of the curette will do this. We have thus briefly stated why we advocate the use of the curette.

When to use the curette is often a very difficult matter to decide. However, by bearing in mind a few anatomical and physiological facts, we can generally tell when its use is indicated. The lattice-work arrangement of the muscular walls of the uterus has an important bearing upon the blood-supply of the organ. The peritoneal covering of the uterus and the mucous membrane lining the uterus, together with the lymphatic supply, are very important factors in the spread of infection. As a matter of fact, the whole inside of the uterus is but a huge lymphatic gland, with numerous ducts and glands deeply penetrating the uterine walls. Indeed, many of these ducts pass through the walls and connect with the para-metritic and pelvic lymphatic glands. We are now prepared to state in a few words how we can tell when to operate. First, let us tell when not to operate. Whenever there is pus in the uterine wall, or around the uterus, or in the adnexa or pelvis, we should not operate, unless we are fully prepared and expect to open the abdomen at once and remove this pus. This is a rule with almost no

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exception. For, even though we do not reach or disturb this pus with the curette, we are almost certain to loosen adhesions and thereby rekindle the inflammation. Then, again, we should not curette when the infection, specific or puerperal, has extended well into the uterine wall and already entered the lymphatic circulation. The curette should never be used in phlebitis of the pelvic vessels, or general sepsis. I wish, at this point, to emphasize the necessity of accurate diagnosis as to the exact location of the poison, for not all cases of infection following abortion, miscarriage, or labor, call for the use of the curette. We must first ascertain whether the poison is confined to the uterus and properly walled-off from the rest of the system. If it is not properly walled-off, the lymphatics and pelvic blood vessels are probably already involved. The use of the curette in these cases simply hastens the death of the patient.

Now, a few words as to when we should operate. Ever bear in mind the fact that nature always tries to prevent, as best she may, the entrance of poisons into the system, and also bear in mind the further fact that when these poisons have entered the system nature tries to combat or overcome their evil effects. In the former effort nature forms a barrier between the area poisoned and the rest of the system. It is the duty of the physician to appreciate this fact and remove the offending substance before it has time to overcome or break through these barriers. If he does this there will be no general infection. Unfortunately, many cases are not seen in time for this. Then, again, many physicians put off all efforts at removal until too late. In other words, operation is, in their hands a *dernier ressort*. Under such circumstances the operation is often followed by serious results, and the operation is held responsible. In short, the time to operate is as soon as infection is located, and it is the bounden duty of the physician to locate this poison at the earliest moment.

In deciding how to curette we must take into account the actual conditions demanding such an operation. The most important fact to be ever kept in mind in every case where the curette is to be used is this: The cervix must be thoroughly dilated, and it must be kept dilated until the endometrium has entirely reformed and is in a healthy condition. Failure in this particular causes severe pain, and more or less of the debris is retained, thereby poisoning the system or causing the disease to return. In simple, non-infectious endometritis, a thorough removal of all the diseased endometrium is sufficient, if followed by a thorough application of what I call *Iodine compound*. The formula is as follows: Glycerine, 70 per cent; iodine, 25 per cent; carbolic acid (strong), 5 per cent. If there is much sub-involution, follow this treatment by gauze packing. In the infectious endometritis more vigorous

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curettage is demanded. All of the diseased endometrium and glands must be removed, followed by the application of 95 per cent carbolic acid, after the debris has been washed out with a 2 per cent solution of creolin. Of course the application of the full-strength carbolic acid must be done with extreme caution, but very thoroughly done. This is as important as the curettage. In every case after this application of carbolic acid, the cavity is to be packed with a 5 per cent iodoform gauze wet in glycerine. This packing seldom causes pain if the os is properly dilated. If it does cause pain it can be removed. A certain amount of pain is beneficial, as it shows that the uterine walls are contracting and these contractions tend to expel the poison by causing its outward flow through the os. You all know that the natural tendency of the circulation of the lymphatic system is toward the diaphragm, and if we can assist nature in expelling the poison by causing the current to flow out through the vagina we are certainly benefiting our patient. In cases of retained products of conception at any stage of pregnancy, or lying-in period, due care must be used not to penetrate the uterine walls. This is especially an important point to keep in mind in cases of puerperal septicemia, as the walls in these cases are very soft.

Having decided to use the curette, be as deliberate and painstaking as for any other capital operation. It is very easy to do too much or too little with the curette, and serious results follow such sort of work. It is also easy to curette too much in some parts, and not enough in other parts, and thereby injuring the walls, leaving a raw surface, or an open mouth, so to speak, to absorb a portion of the diseased tissue which is not removed. It is best for each operator to adopt and accustom himself to a systematic plan of procedure as this will insure more careful work. The following is a good plan (not the only one, by any means): Place the patient across the bed or close to the end of the table, in the lithotomy position. See that the patient's limbs are held in a comfortable position. Robb's leg-holder or some such pattern is good. See that the lower bowel is thoroughly emptied. Be very thorough with all aseptic and antiseptic details. Any good antiseptic will answer. Green soap and hot water are essential. Clip, but do not shave, the external genitals. Always give an anesthetic. Use the duck-bill speculum, steadying the cervix with a volcella. Ascertain the direction and depth of the canal. In cases of ante-flexion, seize the anterior lip of the cervix and in retro-flexion seize the posterior lip. This gives a better chance to use the curette thoroughly above the point of flexion, and this is usually the place where most of the diseased tissue is deposited. Use what is called the rapid method of dilation, but do not use too much force in dilating. Take time to be thorough, but do not destroy the integrity of the cervical tissues. Use as large a

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curette as will readily enter the cavity. Small sizes penetrate the walls more easily as a rule. Do not use the sharp curette. When it is necessary to remove a good deal of the glandular tissue the sharp curette is essential. But be very cautious or you will penetrate the uterine wall. Use the downward motion of the curette for the cervix and the lateral walls of the uterus. Transverse motion of the curette for the fundus. Be sure that each cornu is thoroughly cleaned out, and continue use of curette until the walls are smooth. Use the double current intra-uterine douche. Swab with gauze, and apply proper antiseptics with extreme care and thoroughness. Do not leave an excess of the strong solution in the cavity. If you pack the cavity remove it within twenty-four hours, or sooner, if it causes pain. Be governed by the necessity of the case as to how frequently you clean out the cavity. Some cases will need no treatment whatever. Others may need the treatment twice a week for a month or two. As a rule, one curettage is sufficient. Let me repeat, keep the os well open and keep the cavity clean. Apply the perineal pad and retain it by a T-bandage until the endometrium is healed. In cases of abortion or normal labor it takes six weeks for the site of placental attachment to heal.

A case illustrating important points in the technique of curettage will be of interest.

A woman forty-six years of age with the following history: Eight years ago she gave birth to a full term fetus, which had been dead several weeks. The fetus was badly decomposed, and her system thoroughly saturated with poisons. The expulsion of the fetus was left to nature, which process, owing to the fibroid condition of the uterus, was long and tedious. The placenta was not expelled for nearly three weeks after expulsion of the fetus. As would naturally be expected, the patient was confined to her bed with puerperal septicemia for six or eight months. The first four weeks of this period she was desperately ill. About eighteen months after this illness she began flowing excessively at each period. This condition continued for three or four years, at which time the attending physician discovered a polypus in the cervix. This being removed the hemorrhage ceased for several months. About two years ago she again began excessive flowing, which process continued to increase until I saw her a few weeks ago. At this time she was very pale from loss of blood, having a marked cachexia. The blood-count showed an enormous increase of leucocytes, and the corresponding diminution of the red cells. A careful analysis showed the kidneys in a fairly good condition. Under an anesthetic (by the way, never give an anesthetic until you test for urea) the following conditions were found to be present: The pelvis was completely filled with a large, hard, immovable mass. The os dilated to nearly two

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inches. Presenting at the os was a hard, nodular mass. The finger could be easily swept around the entire circumference of this mass. A very fetid discharge, dark and stringy in character, exuded from the uterus. This odor was simply overpowering. Abdominal palpation showed that the mass extended above the umbilicus, filling the entire part of the abdomen. With two fingers in the rectum, by exercising considerable force, the mass was found to be movable. Passing the sound caused profuse hemorrhage. The uneven surface of the abdominal portion of the tumor led us to the conclusion that we had several interstitial fibroids to deal with. Of course it was very clear that there was a large fibroid in the uterine cavity. This tumor had already undergone degeneration to a considerable extent. We decided at once to thoroughly dilate the cervix and remove this degenerated fibroid through the vagina. This required several minutes and we also found it necessary to cut this tumor into several pieces. During this process the hemorrhage was very serious. But as soon as the entire tumor was removed the hemorrhage was easily controlled. We now reached a critical point in the treatment of this case. The patient was too weak for us to consider for a moment the advisability of opening the abdomen to remove the growth. On the other hand, it would never do to return this patient to bed with this diseased tissue remaining in the uterine cavity, for we had already produced a large raw surface in the uterine cavity with the instruments, in addition to what had been produced by the irritation of the tumor. So it was decided to hurriedly and vigorously curette the uterine cavity. And now comes the interesting feature of the case. This intra-uterine fibroid originally started in the left wall of the uterus. The action of the uterine muscles and the lessened resistance naturally tended to force the tumor into the uterine cavity. When this tumor was removed we found the left wall of the uterus very thin. In fact, very little of the muscular wall remained. The least force with the curette would have penetrated this wall. All other portions of the uterine wall were very thick and nodular. Above these nodular masses, or fibroids, were found large masses of diseased endometrium. These must also be removed, but we found it an exceedingly difficult matter to do this without rupturing the thin portion of the uterine wall. After this was accomplished strong carbolic acid was applied, the uterus packed with gauze, and the patient put to bed. She rallied nicely from the operation. The packing was removed, the cavity cleaned, and the packing replaced each day for ten days. During this time the patient so far recovered her strength that an operation for the radical removal was deemed advisable. The abdomen was opened from the pubis to the umbilicus, as a large umbilical hernia was present. This was dissected out, the uterus and the mass

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of fibroids removed, and the patient made a satisfactory recovery. I have cited this case to show how cautious must be the use of the curette in one part of the uterus, and how vigorous must be its use in another. And only those who are adepts in the use of the curette can treat such cases successfully.

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SALPINGITIS

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Salpingitis or inflammation of the fallopian tubes is a common disease. Some writers claim it is found in twenty per cent of all diseases of the female pelvis, while others place the estimate as low as six per cent.

Doubtless those whose private practice or clinical work is largely among prostitutes suffering from frequent attacks of gonorrhea, or among women who are the subject of frequent abortions, find a much larger percentage of tubal inflammation than those whose practice is among the middle classes where the above conditions are comparatively unknown; gonorrhea and instrumental infection of the uterus being responsible for a large percentage of all cases of salpingitis.

In simple catarrhal salpingitis the mucous membrane is the part principally affected, the muscular coat being but slightly infiltrated. The mucous membrane is edematous and hyperemic. The epithelial cells and the folds being glued together may form closed cavities. The increased secretion shows mucus and epithelial cells.

In purulent salpingitis the mucous membrane is first affected, but the inflammatory process soon extends to the muscular coat and connective tissue, giving the tubes a swollen, distorted appearance. The peritoneal covering becomes infected, causing adhesions to neighboring organs. The tubes often become constricted in places, giving them a link sausage appearance. The fimbriated extremities become agglutinated and inverted or adherent to the ovary.

Pelvic peritonitis usually accompanies salpingitis to a greater or less extent. This may be caused by infiltration of the infection directly through the walls of the tube or it may follow along the mucous lining to the ostium abdominale, through which it pours, infecting the ovary and surrounding peritoneum.

The inflammation may end in resolution or abscess; more often the latter when the infection is purulent.

When an abscess forms the tube may be distended to the size of a finger or it may become as large as a good-sized cocoanut. The tumor formed is usually sausage shaped or pear shaped, the smaller portion being near the uterus.

Etiology.—Salpingitis is in nearly every case an extension of the inflammation from the uterus. The infection may be carried directly

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from the uterus through the ostium internum into the tube or it may be taken up by the lymphatics of the uterus and the broad ligament to the tube. In the former case the salpingitis is primary to the pelvic cellulitis. In the second the pelvic cellulitis precedes the inflammation of the tube.

The former condition is most often the result of gonorrheal infection; the latter is more often the result of septic infection following miscarriage or labor.

Tubercular inflammation of the tubes may occur as a primary disease. In one case of tubercular salpingitis which came under my care, and which I may have reported before, the patient, although thirty years of age, had never menstruated. I removed both tubes and one ovary, and, strange to say, the patient soon began to menstruate regularly and her health has remained good ever since the operation, now nearly three years.

Salpingitis is essentially a disease of active menstrual life. It may occur before puberty from gonorrheal infection or from local peritonitis caused by appendicitis, as in a case which I saw with Dr. Haselton at the German-American Hospital. It may occasionally occur after the menopause, usually as the result of cancerous or tubercular infection.

As suggested at the beginning of this paper salpingitis is found most often:—

First, in prostitutes and in young married women (and some older ones) whose husbands have been indiscreet before or after marriage; or,

Second, complicating cellulitis following miscarriage or abortion.

Most cases of purulent salpingitis are of gonorrheal origin. When gonorrhea once enters the uterus it is apt to extend to the tube. Astringent vaginal injections or tampons greatly increase the liability of the gonorrheal infection to extend to the tubes; just as in the male the strong injection may drive the infection to the epididymus.

Catarrhal salpingitis may be brought on by exposure to cold, excessive and violent coitus, or by violent exercise during or just before menstruation. Here again antiseptic and astringent applications taken to relieve a simple leucorrhea is more often the real cause than the factors mentioned above.

Instrumentation is a frequent cause of salpingitis. The uterine probe in the hands of an uncleanly physician is responsible for many cases of uterine and tubal infection.

The sharp curette is another frequent cause. This instrument should never be used in cases of infected uterus except perhaps in cancer cases. In all cases of placental debris and soft granulations the blunt or semi-blunt curette answers equally well and does not leave the mouths of lymphatics gaping as does the sharp instrument.

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Symptoms.—The symptoms characteristic of salpingitis are pain, tenderness, fever and intermittent leucorrhea; in fact, all the symptoms mentioned, except perhaps the tenderness, are intermittent.

The symptoms may begin with a chill, but more often the chill, if present at all, comes on later and is an indication that the septic infection is pronounced and that the inflammation will end in suppuration. The disease may progress, however, to suppuration and even to a fatal termination without a pronounced chill.

Chilly sensations are a frequent accompaniment and, like the pronounced chill, may indicate profound sepsis.

Both sides are often affected, but the disease usually begins on the left side. So far as the writer's personal observation has gone it may be said that the disease *almost invariably* begins on the left side, and if only one side is affected it is the left.

Why this is so cannot be definitely stated. It has been suggested that the left side of the uterus being more frequently torn may be a cause. In the writer's experience, however, the left side is generally the one affected even in those who have not borne children.

Another reason assigned is that the left ovarian vein has no valves, but why that fact, in itself, should cause sepsis to invade the left tube is not clear.

It seems to the writer that a better explanation is in the fact that the return circulation from the left side is interfered with by having to pass under the sigmoid, often distended with hardened fecal matter; this pressure producing congestion of the tube and ovary of that side predisposes to infection.

Prognosis.—In the *catarrhal* form of salpingitis is usually favorable though resolution may be tedious. In the purulent form the prognosis is always serious. The disease may cause sudden death by rupture into the peritoneal cavity setting up general septic peritonitis. It may drag along and the patient die of exhaustion. In some cases even when the infection has ceased the patient may suffer intolerably from adhesions or atrophy of the tubes and ligaments.

Most cases of septic salpingitis involving both tubes cause sterility.

Treatment may be prophylactic, medicinal, local or surgical.

Prophylactic treatment consists in exercising care, especially at the menstrual period. The patient should be cautioned against sitting on the damp ground, taking cold baths, over exercise, etc.

When there is an active gonorrheal or catarrhal vaginal or uterine discharge, the patient should not be allowed to use strong antiseptic or astringent douches, nor should the physician use them in swabbing out the uterus.

In case of miscarriage the uterus should be cleaned out *at once*

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with a blunt curette—do not wait until infection has actually taken place.

Childbirth cases should be conducted in such a cleanly manner that infection cannot occur, and if, on examination, it is discovered that fragments of afterbirth remain in the uterus it should *immediately* be cleaned out with a blunt curette.

In those cases where salpingitis already exists no instruments should be introduced into the uterus except to remove decidual remains, and then great care should be exercised not to carry infection into the womb, thereby increasing the difficulty. No plastic operations should be performed upon the uterus if avoidable while an active purulent salpingitis exists.

Medical Treatment.—The indicated homœopathic remedies will do much to control the inflammation and prevent suppuration, especially in the catarrhal form. *Aconite, belladonna, ferrum phos., and bryonia,* are perhaps most often indicated in the earlier stages. Later *arsenicum jod.,* or *merc. sol.,* should be given to aid resolution. I cannot speak too highly of the two last mentioned remedies in this connection. I believe they will save the necessity for surgical interference in many cases.

Echinacia has come into use during the past few years as an antidote to the general septic invasion.

Locally perhaps one of the best applications per vaginam is ichthyol and glycerine 1 to 4. In some cases I have seen most excellent results follow the packing of the vagina with wool tampons thickly covered with some of the clay preparations, such as antiphlogistine. A clay poultice over the lower abdomen will relieve the pain and tenderness and may possibly aid resolution.

Hot vaginal douches, or better, hot rectal injections are beneficial if given in sufficient quantity. The latter serves a double purpose; it brings the application of heat close against the inflamed tissue and at the same time acts as an enema.

Galvanism may be an efficient aid in the chronic form if applied intelligently; careless use of electricity in these cases may do more harm than good. In this connection I quote Dr. Massey, who says, "the considerable number of instances in which apparently closed pus tubes have been rendered patulous and capable of performing their functions by a combination of vaginal and intra-uterine treatment," coupled with a statement recently made by Dr. J. M. Baldy, an uncompromising advocate of the knife, that many tubes removed for pus accumulation are found to contain none at the time of the operation, should all tend to check a too hasty amputation of a yet curable organ.

Should the tube, on the other hand, be firmly fixed by well organized adhesions and be the seat of an active accumulation of pus rather

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than muco-pus, the chances for a cure by the ordinary electric treatment are very remote. As a rule my own practice is to regard pus tubes of distinctly gonorrheal origin as inadmissible of cure in this way.

Surgical Treatment.—Surgical interference should either be adopted early in the case before surrounding viscera are involved, especially if the infection is known to be gonorrheal, or else postponed until definite symptoms of pus accumulation are present. It is bad surgery to cut upon or tear loose edematous and friable structures in the abdominal cavity. It is better to wait until a pus cavity has formed, if resolution cannot be effected, and then evacuate the abscess and drain, or, if the pus tube can be removed entire so much the better. This, however, is a difficult thing to do as the adhesions are usually firm and the pus tube is thin in places, and it is very seldom that it can be dug out of its bed without rupturing it.

It is seldom that a collection of pus in the tubes becomes inspissated, and even if the liquid portion is absorbed there is always a residue which acts as an irritant and re-infection is apt to take place. It is always best therefore to remove pus tubes as soon as the active inflammation has subsided, or, if complete removal is not indicated the sac may be evacuated and drained through the abdomen or vagina.

In this connection I quite agree with our worthy President in stating in his text-book that in dealing with the cystic diseases, blind conversatism is most reprehensible. A woman who has a distended fallopian tube and who suffers from frequent attacks of peritonitis can have no greater misfortune come to her than fall into the hands of a physician incapable of comprehending the dangers which beset his patient The medical attendant advises against an operation and the case progresses from bad to worse until finally a point is reached where an operation, if done at all, must be done when she is practically moribund.

If, however, the *ostium internum* is patent, allowing free drainage of the pus into the uterine cavity, the removal of the tubes should be postponed until all reasonable methods have been tried to cure the discharge.

The three points, then, which we wish to emphasize, are these:

1st. The frequency of infection following badly managed cases of gonorrhea and abortion.

2nd. The tendency of astringent douches and tampons to drive infection to the tubes.

3rd. Bad judgment of the attending physician in allowing the case to go too long when surgical interference should be adopted, and, bad surgery on the other hand in attempting to enter the abdomen and remove congested tubes before nature with the aid of the indicated

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remedy has had a chance to bring about resolution or until pus has become localized.

In this connection I wish to again quote Dr. Ochsner, of Chicago, who probably has had as large an experience in these cases as any man in the United States. In a recent conversation Dr. Ochsner said: "Formerly we used to operate on the cases of salpingitis and cellulitis which came to us as a result of miscarriage," and, to use his expression, "they died like flies." "Now," said he," we put these patients to bed, take away food, and wait for resolution, or, if pus forms, evacuate it, and it is seldom we lose a case."

DISCUSSION:

DR. C. B. KINYON: In just about one minute I can say all I care to. I am going to say something that some of you wont believe, but I do. I have seen enough of the results of young men sowing wild oats to lead me to make this statement, that in ninety per cent and more of the men, young and old, who have ever had ghonorrhea that was not cured, in other words, was followed by what they call gleet, would afterwards give infection to the wife, that would produce salpingitis and every other damnation that follows. Now, if we could teach our boys that this fact is true, they are not going to take the chances that they do take—that is, a good many of them will not. But the curse on the part of the medical profession is that they will say: "O, well, the boys will come to them after they have the disease. I will fix that for you all right. You need not worry about it. Everybody has that." This is one of the most damnable heresies on the face of the earth, and any doctor who will say that is almost as bad as the boy, and I guess in some cases worse.

Just one word in regard to the paper, in reference to the treatment, and that is this: We sometimes have cases in which it is pretty difficult to know whether the pus is walled off, or whether or not we are going to have complete resolution. In other words, we do not know exactly what is going on. You do not want to open that abdominal cavity from above, but I will tell you what you can do with perfect safety, never doing any harm, and oftimes curing many cases. Resort to Prior's operation, which is nothing more nor less than cutting into the *cul de sac*. If you find pus or simple products of inflammation, pack in gauze, remove and repack, *etc.*, until the patient is perfectly cured. I have used this method in some of the worst possible cases, in which the patients were so desperately sick I hardly thought it worth while to go through the abdomen at that time, or safe to do so. The first year or two I performed this operation of Prior's, I said: "I will go up through the *cul de sac*, because that is all the patient can stand, and later I will perform the operation if necessary." I did not believe Dr. Prior altogether; but I find he does not put the case any too strongly. I have been astonished at the number of cases that have been promptly cured, so far as I know, by continuing that drainage until everything from above is cleaned out and healed up.

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THE OPERATIVE TREATMENT OF CANCER OF THE RECTUM

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When this title was submitted to the Section in Gynecology, the author had only executed the operation once, and then upon a woman; therefore, the subject came very properly before this section. Since that time the operation has been executed again, with slight modifications of technique, on this occasion upon a man. We trust however that a slight modification referred to will not render the subject out of the ordinary field of work in this section. The operation to be described was executed without a knowledge of the many procedures which will be referred to in this paper, and was, so far as the author is concerned, an entirely original procedure. After a very protracted search of the literature, involving weeks of work at translation and abstracting, we find that somewhat similar procedures had been executed, notably by Dr. Schwartz of Agram, Croatia, reported in *Centralbl. f. Chirurgie,* 1889, page 134. A close comparison of methods, however, shows variation enough to warrant, in our judgment, a detailed report of the procedure and a painstaking attempt at definition of its applicability to a certain class of cases.

The literature of this subject is so voluminous that nothing but the briefest outline will be given at this time, and if the style is somewhat epigrammatic, we trust that it will be pardoned, since it will result in much time-saving for the section. The first question which comes before us is the decision as to whether radical operation for cancer of the rectum is or is not a justifiable procedure. You will recall that men having such a broad experience as Dr. Kelsey of New York have frequently advocated the abandonment of attempts at radical extirpation of cancer of the rectum, and have contented themselves with performing either inguinal or lumbar colotomy. As bearing upon this point we beg to quote the statistics collected by Quenu, as follows:

Billroth	1 case	4 years	Czerny (Cont'd)	8 cases	5 years
Volkmann	2 cases	5 years	"	1 case	7 years
Esmarch	1 case	3 years	"	1 case	9 years
"	1 case	4 years	"	1 case	11 years
"	1 case	8 years	Kraske	65 cases	2 years
"	1 case	11 years	"	15 cases	2 years
Czerny	99 cases		"	2 cases	5 years
"	15 cases	3 years	"	2 cases	9 years
"	15 cases	4 years			

We therefore see that notwithstanding an admitted immediate mortality of from 18 to 22 per cent that the ultimate results of complete ex-

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tirpation seem to warrant our persistent efforts toward a more perfect operative procedure.

In considering and weighing the various methods which have been executed for the removal of this terrible disease, we must look at the operation from the same standpoint occupied by such men as Halsted, Cullen, and Kelly in their view of the treatment of cancer in other portions of the body. Not only these masters of operative technique, but surgeons in general, have within the past few years, abandoned the comparatively simple methods of extirpation; for example, have abandoned vaginal hysterectomy for the more complete abdominal operations, have abandoned the ordinary excision of the breast for the more complete operation which bears the name of Halsted, and have, in a word, gone over to the side of the most radical extirpation possible. In other words, we now recognize that by the time a fairly positive diagnosis of cancer can be made, the disease has already ceased to be strictly local, and has, without question, involved the lymph-nodes in that direction in which the lymph-stream is flowing, and if a procedure is to be considered at all radical and is to offer the patient any hope whatever of ultimate recovery, it must contemplate not only the removal of the growth, the entire organ in which it is situated, and all of the macroscopically involved surrounding structures, but it must remove all of the lymph-nodes which can be removed without jeopardizing the life of the patient.

Previous to the time that the technique of abdominal surgery reached such a stage that the operation of laparotomy itself could be considered practically devoid of danger, operations directed toward the removal of cancer of the rectum were of a very incomplete nature, and the growth was always attacked from below or from behind. Among the operations of this sort are the procedures of Hochenegg, Zuckerkandl, Wolfer, Heinicke, Levy and Bardenhauer, all of which are so incomplete that they merit no consideration on our part at this time. Ledru, in '91, dilated the sphincter, pulled out the growth and excised it. Hartman, in '93, advocated the same operation, but succeeded, however, in saving the lower segment of the rectum.

Schelky, in '92, and DePage (Belgian Surgical Society, '93). advocated a transverse incision in the perineum in order to remove more tissue from below.

Even as early as 1876 Furneaux Jordan called attention to the superficial location of the rectum in woman, and hinted at the availability of the vaginal route for its extirpation. Twelve years later A. T. Norton of Paddington, England (1888), split the perineum and removed the lower rectal segment with the ecraseur. This, however, was in a case in which the recto-vaginal septum was involved. The next year, however, he executed practically the same procedure for the removal of a cancer of the rectum itself.

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Heron of Geneva, in March, '94, separated the vagina and rectum and afterward incised the septum, removed a cancerous segment of the rectum, preserving the sphincter. In the next year Rehn reported his "vaginal method," stating that he had been led to its adoption, not as the result of the work of other men, but as the result of many dissections upon the cadaver. Two years later Liermann, Rehn's assistant, published an exhaustive article, describing in detail and advocating Rehn's vaginal method. This consisted briefly in a circular incison around the anus, sparing the sphincter, incision of the recto-vaginal septum, opening of the *cul-de-sac,* freeing the rectum, drawing it down and incising it, closure of the *cul-de-sac,* suture of the rectal ends and suture of the perineum. Byford, in '96, excised a portion of the rectum through a transverse vaginal cut, while Sternberg, writing from Professor Gersuny's clinic in 1897, says that he, Gersuny, had at that time operated fourteen times by the vaginal route.

Now, all of this work attempted through the vagina may well be credited to the familiarity which gynæcologists had acquired, through their experiences with vaginal hysterectomy and the various operations for the repair of the vaginal outlet. At this same time men of a more purely surgical tendency and experience had for years been attacking the rectum through a posterior cut of one sort or another. As early as 1874 Kocher brought out and popularized his method, which reached the rectum by means of a soft tissue cut extending from the anus on to the sacrum and involving the exarticulation of the coccyx. This method, however, gave poor access to the upper portion of the rectum, and Kraske, in 1886, devised the sacral method, modifications of which have been advocated and bear the name of Hochenegg, Bardenhauer, Levy, and Rydygier. Heinicke also approached the rectum through the sacrum, but it is under the name of Kraske that the operation gained its widest notoriety and its greatest following. This operation, so far as I am able to learn, never became very popular outside of Germany, and outside of German influence. The procedure is one of enormous severity, involving a section of the sacrum, accompanied by terrific hemorrhage and resulting in an enormous mortality; certainly not less than 25 per cent.

One of the greatest disadvantages of the Kraske method is the fact that the height of the sacral resection must be limited at the third sacral foramen, for the reason that any severe traumatism to the nerves emerging at that point results in permanent paralysis of the bladder and rectum. While it is possible in many cases to mobilize a number of inches of the rectum from above this point, bringing it down within reach, still all these manipulations are done at a great disadvantage and in a field filled with blood.

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The Kraske method met with very strong opposition at the time it was first reported, and even then, now over twenty years ago, Volkmann, the old war-horse of general surgery, predicted that we should ultimately learn to remove the rectum by a combined abdominal and perineal cut. The abdominal route, however, found no advocates, so far as I am able to learn, until 1882, when Czerny did a laparotomy for cancer of the upper end of the rectum, a description of which operation leaves the impression upon one's mind that it was merely an excision of a portion of the sigmoid. He finished the case by the construction of an artificial anus. In 1899 Koenig, who had not previously reported his cases, claimed (*Berl. Klin. Wochenschrift*) to have done a combined abdomino-perineal operation ten or twelve years previously, and all authors seem to have credited him with priority for this procedure. We are unable to find the exact dates upon which Kraske, Czerny, Beckel and Bardenhauer were each forced to do a laparotomy in conjunction with their Kraske operations in order to cope with one accident or another which had befallen them during the procedure.

While the Germans were attacking the rectum by means of the posterior route, involving the bloody sacral resection, the French were perfecting their technique of vaginal hysterectomy and were becoming adepts in executing pelvic surgery through this narrow opening, and it is to Gaudier that we must credit the first carefully planned and executed abdomino-perineal operation for cancer of the rectum. This was reported by Quenu in 1896, and was in brief as follows:

Trendelenburg posture, medium laparotomy, double ligature of the sigmoid, followed by its division. Second stage—Lithotomy position; circular incision about the anus, isolation of the rectum; division of the levator ani; freeing of the gut from its meso-colon, with extraction of the entire lower segment through the perineal wound; formation of artificial anus in the lower angle of the abdominal incision.

One month after this Chalot of Paris reported a similar operation, which differed principally in the fact that the abdominal incision was placed in the left inguinal region instead of in the median line. The lower segment was removed through the perineal incision, but the operation was, unfortunately, not successful. The membranous urethra having been torn, the patient died the next day of uremia.

The next operation of importance in this line, and probably the first well-planned and executed operation for removal of the rectum by the abdomino-vaginal route was executed by Dr. Carl Schwartz, November 8, 1898. This operation resembles my own procedure so closely that I will, with your permission, omit its detailed description, and later call attention to the slight difference of method. I wish at the same time to

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be understood as granting to Dr. Schwartz unquestioned priority both of execution and report.

Following the reports of the work of Chalot, Gaudier and Schwartz numerous other operators have reported abdomino-perineal methods, but none of them is distinctive enough to demand our attention at this moment, and any one interested in this subject is referred to the recent exhaustive and highly admirable work of Quenu and Hartman upon cancer of the rectum.

Before proceeding to a description of our own operation and report of the two cases upon which it has been executed, some consideration must be given to the recent work of Kraske, probably the greatest living authority upon the operative treatment of cancer of the rectum. Our knowledge of Kraske's present position is derived from a most excellent review of the subject of rectal cancer which appeared in the *New York Medical Times* in July and August, 1901, being a translation of the Inaugural Thesis of Dr. H. Otto Sommer of Washington, whom I am proud to quote as one of the members of this Institute. Dr. Sommer's thesis is evidently based upon three cases operated upon by Kraske according to his new method, and the whole article seems to have the sanction of this high authority, and may therefore be considered an authoritative description of Kraske's method.

Kraske seems to have arrived at the same conclusion with regard to rectal cancer which we all hold with regard to cancer in other locations of the body, *viz.:* that the operation must have for its object exploration of the entire abdominal cavity in order to eliminate metastatic growths in the liver or in other portions of the abdomen, must contemplate the entire removal of the growth itself, and, most important of all, must give free access to the mass of fat and glands lying within the sacral hollow and occupying a position relative to the primary growth similar to that occupied by the axillary fat and glands to a primary carcinomatous growth in the breast. Kraske also lays great stress upon the advisability of preserving the function of the sphincter, and he criticises strongly the French surgeons who seem to have placed so little weight upon this function.

His present method consists first in an abdominal incision in the left inguinal region, the cut running parallel with Poupart's ligament, extending almost to the median line. The next step is executed exactly as will be described in the author's operation, consisting of freeing of the sigmoid and rectum from behind forward, down as low as its exit from the pelvis, or to a point two centimeters below the lower limit of the growth. All of this after ligation of the superior hemorrhoidal artery. He now determines whether it is possible to approximate that portion of the intestine lying just above the upper limit of the growth

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to that portion lying just below its lower limit. If this is not possible he nicks the peritoneal covering of the meso-sigmoid to such an extent as to permit this approximation. He now tampons the pelvis with gauze strips, closes the abdominal incision by a gauze pad, places the patient in the right lateral position and executes a para-sacral cut, which brings him to the rectum from its posterior side. He resects the coccyx, splits the levator and muscle, draws out the cancerous mass and makes an end-to-end anastomosis of the rectum and sigmoid, making a great point of the fact that the intestine is only opened after its removal from the abdominal cavity.

One sees by this description that Kraske has practically abandoned the sacral resection and has substituted for it the more logical and to our mind the vastly superior abdominal incision, and in this connection we beg to mention a valuable article written by Dr. Edebohls, of New York, in 1901, in which he calls attention to the non-necessity of the old Kraske procedure, particularly in women, and says in substance that a combined vaginal and abdominal incision will give free access to all parts of the rectum, and that by abandoning the sacral resection an enormous danger and much hard work are avoided.

Passing over now the abdomino-perineal, abdomino-sacral and abdomino-rectal operations recently reported by a number of authors, notably Schuchardt, Koenig, Robert F. Wier, Quenu and Sonnenburg, we beg to present a brief description of a case, together with photograph and an abstract of an operation which we have executed, and which we believe to be superior to anything yet described for cases of cancer of the rectum involving a long strip of the gut and extending to a point lower than 2½ inches above the anus. We also wish to advocate this operation for all cases of cancer of the rectum in women where it is necessary to remove such a large section of the intestine that the two ends cannot be safely approximated by means of the new Kraske operation described above.

Case 1. Mrs. R. Age 47; married; multipara; youngest child, 20 years of age. Father died of diabetes; mother of puerperal fever. When the patient was eight years of age she had tuberculosis of the knee-joint, for which the left limb was amputated at the middle of the thigh, at the age of 32. She has suffered from procidentia, has been operated upon for lacerated perineum and cervix, and has had a ventro-suspension, together with amputation of the cervix. Her rectal trouble has been diagnosed as hemorrhoids, has been associated with abdominal pains and bloody stools. Upon examination a fairly tight stricture is found one inch within the anal ring, the whole rectal mucous membrane is nodular and indurated, and as high as the finger can reach another

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stricture is detected. Diagnosis, adeno-carcinoma, probably extending so high as to be beyond reach from below.

Operation, January 10th, 1902. Time, 3 hours and 35 minutes.

Trendelenberg posture.

Median abdominal incision, from umbilicus to pubes.

Examination of liver and other inter-abdominal organs excludes metastatic deposits.

Incision in left inguinal region parallel to Poupart's ligament just internal to anterior superior spine, 1½ inches long—separation of fibers of external oblique in the same line, separation of fibers of internal oblique at right-angles (similar to McBurney's incision for appendicectomy). Incision through peritoneum in same line.

Incision upon anterior surface of the upper portion of the thigh, parallel to and about 2 inches below this incision.

Dissection through superficial fascia from one cut to the other, leaving a bridge of skin.

A clamp is now passed through the lowest incision up underneath the bridge of skin and into the abdominal cavity, through the higher lateral incision, and grasps at right-angle a portion of the sigmoid, the mesentery of which is long enough to allow the end to be drawn down through the incisions to the skin surface.

The sigmoid is now milked from the clamp downward until it is thoroughly emptied of fecal matter, when the sigmoid is grasped by another pair of clamps in exactly the same manner at a point one-half inch below the first pair, this second pair passing into the abdominal cavity through the median incision.

The gut is now severed at right-angles between these clamps, the cut ends are thoroughly freed from intestinal contents, the peritoneal layers forming the mesentary of the proximal end are carefully nicked with the scissors until this proximal end can be carried down through the two incisions to the skin surface of the thigh.

Now, with long-handled blunt scissors curved on the flat the left peritoneal layer of the meso-sigmoid and the meso-rectum is incised, beginning at the transverse cut of the sigmoid, and extending down to Douglas' *cul-de-sac*—incision in a similar manner of the right peritoneal layer of the meso-sigmoid and the meso-rectum extending to Douglas' *cul-de-sac*, and this incision prolonged forward around the rectum to join the former incision, thus encircling the rectum at its exit from the abdominal cavity. Now with the long forceps and scissors a flap of peritoneum is raised from the anterior surface of the sacrum, and the superior hemorrhoidal artery is isolated and ligated just as it leaves the promontory to pass forward and downward between the layers of the meso-rectum to supply the rectum. Ligature of this artery at this time

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renders the rest of the operation practically bloodless. Usually one or two small ligatures are required to control branches of the mesenteric artery supplying the lower portion of the sigmoid. Now, while the assistant draws forward the upper end of this lower or rectal segment the surgeon can by blunt dissection tear off from the anterior surface of the sacrum all of the fat, glands and other structures, leaving them attached to the rectum. This process is continued deep down into the pelvis, tearing from the sides toward the rectum, separating the top of the vagina from the rectum, completing the isolation down to the attachment of the lavator-ani.

The assistant now passes a uterine dressing-forceps into the vagina and up behind the cervix, making it prominent enough to be detected from the abdominal side. Blades of the forceps are now opened, and with the scissors we cut between them into the vagina, making a longitudinal incision two inches or more in length; closing the forceps again they protrude into the protineal cavity, are once more opened and between their blades is placed the upper end of the now detached rectal segment. Forceps closed and withdrawn through the vagina, bringing with them the whole of the rectum, which formerly laid above the levator-ani muscle, the cancerous growth, all of the lymph-nodes and fat from the sacral hollow, in a mass. This mass now protrudes from the vagina and is ignored for the present.

Continuous suture of the peritoneal incisions and flaps, peritoneal toilet, suture of the median incision in layers, temporary dressing.

Lithotomy position, rectum held forward against the anterior vaginal wall with long retractor, median incision of perineum, extending from the top of the vagina to and encircling the anus.

Isolation of the rectum from below upward, cutting rapidly and wide of the growth.

Excision of the entire mass from below—perineorrhaphy gauze drainage in top of vagina, perineal dressing.

Prone position, permanent abdominal dressing after suture of superficial lateral wounds and suture of intestinal end to skin-surface on thigh.

It remains for us to acknowledge credit to Witzel, of Bonn, for the above method of constructing the artificial anus, and to state that Witzel probably got his idea for this procedure from the Sabanijew-Franck method of gastrostomy.

In considering the Schwartz method of abdomino-vaginal proctectomy, we would say that it seems to correspond with the above outlined procedure in all respects—except that the abdominal incision instead of being median was in the left lateral position, just above and parallel with Poupart's ligament, and that Schwartz attached the end of

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the sigmoid, forming the artificial anus by means of a crown suture. We submit that the median incision gives easier and more direct access to the sacral hollow, that it leaves an abdominal wall which is stronger than that which is left following the lateral incision. The crown suture seems, from our experience, to be unnecessary, and may therefore be very safely omitted.

Our conclusions in regard to these cases are briefly as follows: *First,* the advisability of preserving the sphincter cannot be doubted, and we believe thoroughly in its feasibility in those cases where the cancer does not extend lower than 2½ inches above the anus, nor higher than a point which can easily be approximated to the cut-off lower segment. For the treatment of these cases in man we believe the new operation of Kraske to be most advantageous; in women, however, it seems to us that a similar procedure can be better executed by the vaginal route, following the technique of the French surgeons.

Second, where the cancer overlaps these limits we believe that our procedure is the best yet devised.

Third, we submit for discussion the bald statement that all cases of rectal cancer which are not strictly cases of cancer of the anal margin, should be treated by means of one of these combined methods, permitting in every case removal of the fat and glands from the sacral hollow.

DISCUSSION:

E. H. PRATT, M. D.: As Dr. Roberts said, I have not seen his paper, and owing to the unfortunate acoustic qualities of this room I could not hear it so as to get a definite idea. For me to attempt to discuss so scientific and important a paper, without knowing what it is, would not be doing justice to the paper, the author, nor to myself. But since you have called upon me, I will say that there is just one reason why I am willing to speak for a minute. Perhaps I can give you some practical suggestions that will help you in preventing operations—not so much with a view to criticising operations that have been given this evening, as for treating those cases which you and your patient decide are not fit for operation. What can you do in the cases in which you are unable, either for lack of consent on the part of the patient or your own consent, to do the radical work? One word first upon the way of resecting the rectum by the lower method. I have a way of my own that I would like to suggest to you. Instead of doing all the work back of the anus, and instead of removing the coccyx and lower fragment of the sacrum, I should sever the tissues from the scrotum or vulva to the coccyx, splitting the anus, and I should go on splitting the rectum until I could roll it downwards and outwards, until I come as high as the healthy portion. Of course, there are cases in which this is not possible. I am talking of the cases that are possible. Then I would amputate the intestine, and, holding onto the upper fragment with a T forceps, I would skin the mucous membrane from above downwards; then amputate the lower part leaving the sphincter

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intact still covered by mucous membrane, which is to be joined by interrupted catgut sutures to the upper end of the severed intestine.

In bringing down the intestine do not disturb any of the coats except the mucous coat. This is practically a high American operation, bringing down the mucous coat sometimes four to six inches in length, and fastening it to the lower inch, which has not been disturbed; then closing the wound and retaining the sphincters in proper position. I do not think I was ever so pleased with any surgical work I ever did as with some of these operations. The operation is an exceedingly fatal one, and is to be avoided if possible. To avoid the operation or to prolong life and make life as comfortable as possible in cases that are not operable for any reason whatsoever, I should first, of course, establish an artificial anus, the left groin being preferred where the cancer does not come too high to preclude the idea. In the next place I should use local feeding a part of the time. I have used bovinine to great advantage, and there may be other preparations that are good. One of the reasons that I wanted to take this platform this afternoon was for the practicability contained in the following suggestion. It won't cure cancer, but it will cure, in a majority of cases, sigmoidal catarrh, which is often a precursor of cancer. I refer to the use of methyline blue as a colonic application being made by means of Cole's irrigating tube. Two grains of methyline blue dissolved in a pint of tepid water, and by Cole's irrigator thrown into the sigmoid, asking the patient if possible to retain it. The action of this preparation upon colonic catarrh is magical; if the patient succeeds in retaining it, of course you get at the same time a cleansing of the genito-urinary tract, as the urine becomes thoroughly blue as a rule. It is not necessary to continue this treatment for many days in succession.

I must not take my seat without speaking of one form of treatment of cancer proposed by Dr. Monroe, of Louisville, Ky., not A. L. Monroe, but a Monroe whose initials I do not remember, belonging to the "regular" school. It is what he calls a cure by means of slippery-elm. The slippery-elm must be fresh, and made as thick as a saturated solution of the slippery-elm. Two or three glasses of this must be taken by the mouth daily. In addition to this he uses an enemata of slippery-elm. He claims to have cured several cases of cancer of the sigmoid by this treatment. I, myself, in one case that was too far gone to operate upon, where the sphincters were involved and the patient was too hopeless a case for operation, performed artificial anus for him and employed this slippery-elm treatment. The result was that the man lived for two and one-half years, in more comfortable condition than he had known for five years. I thought I had done a much better job than if I had mutilated him below by taking away the coccyx and part of the sacrum and then permitting him to live in a pitiable condition only three or six months at the most, even if he survived the operation.

So the reason I have accepted the invitation to speak is just to give these suggestions about methyline blue and slippery-elm water. And please do not forget that the sexual system and the rectum are twins. If you want to get proper reaction to rectal work you must cure impingement of the terminal sympathetic nerve in the sexual system first. You cannot have one twin sick without the other, and those two parts must

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get well together. Rectal surgeons cannot ignore the genito-urinary system in the male, and gynecologists and those who make a specialty of male sexual questions cannot ignore rectal troubles.

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SALPINGITIS, PYOSALPINX AND PELVIC ABSCESS

J. Emmons Briggs, M. D.
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While a great majority of the diseases which woman flesh is heir to may be said to arise independently of any influence which the patient or her family may exert or have power to prevent, we must come to an exactly opposite opinion when we consider the inflammatory lesions of the Fallopian tubes.

It may be and often is, through no fault of the woman, that she suffers from pelvic inflammation; yet, responsibility for her condition exists. We are not of the opinion that salpingitis arises spontaneously, as is the case in appendicitis or cholelithiasis, but are rather inclined to the opposite opinion, that salpingitis, pyosalpinx, and pelvic abscess are due to very definite and well-understood infections, and these of such a character that they may be considered as preventable.

Inflammatory conditions of the Fallopian tubes are likely to follow infection by the gonococcus or any of the other pus-producing micro-organisms. These usually gain their entrance to the tubes through direct infection of the genital tract. Starting usually as a vaginitis, the inflammation extends by continuity to the endometrium, and later leads to involvement of the tubes.

Little do we hear now-a-days of the intricate pathology of cellulitis parametritis, and perimetritis—diseases which are rarely spoken of at all, as they are the manifest results of an inflammation of the tubes. In rare cases they follow infection from an abrasion in the vaginal vault.

While the text-books of a decade or so ago made free use of the term "idiopathic," in order to convey to the reader's mind the spontaneous origin of disease, it is now considered as a high-sounding phrase which expresses only the ignorance of the profession as to the etiology of disease.

Diseases do not arise idiopathically. There is a direct cause of each, which in the future we may hope to be able to determine. In salpingitis, pyosalpinx, and pelvic abscess the cause has been definitely ascertained, and we are now positive that we can account for these diseases only by infection. It is, therefore, evident that in order to induce a salpingitis a septic condition must exist, usually in the endometrium, and we must conclude that any septic endometritis may be followed by inflammation of the tubes.

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The diseases capable of producing a septic endometritis and by continuity involving the tubes are: 1, Gonorrhea; 2, Sepsis following miscarriage or mature labor; 3, Criminal abortion; 4, Unclean instrumentation in gynecological practice.

1. GONORRHEA.

Gonorrhea is a disease the severity of which has only recently been appreciated. In the male the most frequent and serious complications are lymphangitis, peri-urethral abscess, Cowperitis, prostatitis, vesiculitis, epididymitis, stricture of the urethra, cystitis, dilatation and infection of the ureters, urethritis, pyelo-nephritis, and the conversion of the cortex into a large abscess-cavity. The complications common to both male and female are cystitis, ureteritis, and uretero-pyelitis, gonorrheal conjunctivitis, and gonorrheal rheumatism. In those peculiar to women we have, in addition to those last-named, vulvitis, inflammation and abscess formations in the vulvo-vaginal glands, purulent endometritis, salpingitis, pyo-salpinx, pelvic abscess, also local or general peritonitis, which may end in fatality or necessitate a capital operation in order to prevent a life of chronic invalidism. Gonorrhea is, therefore, no trifling malady in either sex.

In the male the sequelæ, although as serious as in women, are not as likely to occur; in other words, the very serious complications of gonorrhea occur far more frequently in women, and they not only jeopardize the woman's life, but, if she survive, frequently make her sterile and a chronic invalid, suffering from pain in the pelvis due to the chronic inflammation and its attendant adhesions binding the uterus, ovaries, tubes, and adjacent peritoneum into masses of chronically inflamed tissue. Nor is this all, for often the chronic inflammation gives place to acute exacerbation when there is a re-formation of pus and the patient suffers intensely from all the symptoms of an acute inflammation—intense pain, sensitiveness to pressure, rise in temperature and pulse, chills and general malaise. The formation of pus may be considerable, so that the distended tube may rupture or the contents may find an exit through the fimbriated extremity of the tube, or may penetrate the walls of the tubal abscess and disseminate itself directly among the intestines, causing a general peritonitis, but far more frequently the inflammatory process causes extensive adhesions to form between the tubes and adjacent intestines and peritoneum, which effectually walls off the general peritoneal cavity.

With the increase in the accumulation of pus fluctuation may be detected in the vaginal vault; this, however, is rare in my experience, while a boggy swelling filling in the vault and extending in either or both ovarian regions is more common.

That the gonococcus is a true pus-producer there is at present very

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little doubt. Clinical evidence strongly supports this opinion. Gonococci have been the only germs discovered in at least one case of pyosalpinx and one case of gonorrheal ophthalmia which I have attended during the past year.

While the gonococcus may appear alone in rare instances of pyosalpinx, we meet far more often the mixed or secondary infections combining with the gonococcus the more active pus producers, the streptococcus or staphylococcus. Where the gonococci are the only bacteriological elements the inflammatory manifestations are more chronic and the symptoms less violent than in the mixed or secondary infection.

2. Sepsis Following Miscarriage or Mature Labor.

Under this heading we shall confine ourself to the infection caused by the staphylococcus and streptococcus pyogenes, and shall have very little to say regarding the acute attack of puerperal septicemia, confining our attention more strictly to the local manifestation under consideration, *viz.*, the effect upon the Fallopian tubes.

The very acute symptoms of puerperal septicemia arise from the entrance of the before-named micro-organisms into the circulation where they rapidly multiply, resulting in an acute form of progressive septicemia. A less fatal and more controllable condition is that of sapremia, the result of the absorption of the products of putrefaction as illustrated in the putrescent placenta. The patient may succumb to this form of infection if interference is too long delayed, but the emptying of the products of decomposition will result in cure if done before a fatal dose of the poisonous ptomain has been absorbed. These conditions are easy to differentiate theoretically and bacteriologically, but clinically more difficult. The presence of a foul odor to the profuse local discharge, and the occurrence of the attack toward the end of the first week will point strongly toward a sapremia. It is highly improbable that in sapremia saprophytic infection occurs alone; the pus-producers are likely to be implanted, resulting in a true sepsis. Fortunately these septic conditions rarely result in a fatal progressive septicemia, the rule being a purulent endometritis which extends by continuity of tissue into the Fallopian tubes. Here the virulence of the pyogenic bacteria and the amount of resistance which the tissues offer will determine the subsequent history of the infection, whether the result is to be a catarrhal or purulent salpingitis, whether there is to follow a pyo-salpinx or a pelvic abscess. If a salpingitis, there will result a sealing of the fimbriated extremities of the Fallopian tube or tubes (the disease being generally bilateral) with, in all probability, the formation of adhesions and the binding down of ovaries and tubes, usually in the most dependent portions of the pelvic cavity, and they will be found by pelvic examination,

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or at the time of operation, firmly adherent to the posterior aspect of the broad ligament and uterus in the *cul de sac* of Douglas.

Probably this rather uniform location of the ovaries, tubes, and pelvic inflammatory conditions is the result of the gravitation of the abnormally congested and inflamed and heavy structures to the most dependent position in the pelvic cavity, where they become adherent. A life of chronic invalidism ensues, pelvic pain and sensitiveness in the ovarian region being the rule, and sterility is assured if both fimbriated extremities are sealed. A condition more serious than this has, in my experience, followed a salpingitis of one side with a healthy tube and ovary of the other, for here pregnancy may occur and be followed by puerperal sepsis originating from the diseased tube. An active or even quiescent gonorrhea occuring in pregnancy is a potent factor for mischief during the puerperal state.

Miscarriages are more likely to be followed by tubal involvement than delivery at term, which can be accounted for by the fact that there is frequently retention of the membranes which undergo septic or putrescent changes, which in turn are followed by septic endometritis and tubal inflammation.

3. Criminal Abortion.

I am confident that there is no cause of tubal disease more serious or far-reaching in its evil effects than the deplorably common practice of induced abortion. Everything which goes with this nefarious practice is conducive to infection. The principle is bad, and the methods whch are employed in carrying out the practice are equally so. The woman who finds herself pregnant and is unwilling to assume the prerogative of motherhood looks about for some means of getting rid of the products of conception. Knowing, if she be an intelligent woman, that it is useless for her to apply to her family physician, she seeks the advice of some friend of experience and usually employs certain drugs which are recommended. As it happens, no drug possesses specific ecbolic properties. They produce abortion, if at all, more by the general disturbance of the system than by any specific action on the womb itself. They greatly deplete the system, rarely accomplishing the purpose for which they are taken. After experimenting with drugs and trying general measures, such as violent and excessive exercises, *etc.*, all to no avail, she places herself in the hands of the abortionist, and in her greatly depleted condition and perturbation she has fulfilled all the requirements predisposing to infection except the implantation of the septic microorganisms. This the abortionist, by unclean instrumentation and unscientific treatment, supplies.

Then follows the septic developments which so frequently result in death, but more often terminate in tubal involvement and invalidism.

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Could women but know the frightful risks they run, the chances they take, when they assent to this procedure, they might be deterred therefrom through fear of consequences, if their moral sense were ever so calloused.

Would space permit or the value of this paper be enhanced I could cite case after case of women who have lost their lives by this means, and many more who are reaping the reward of their folly by a life of suffering and humiliation.

Criminal abortion, in the writer's opinion, stands next to gonorrhea as the most frequent cause of tubal disease, and far ahead in ratio of mortality.

4. Unclean Instrumentation in Gynecological Practice.

To this should be added the carelessness in the use of the vaginal douche. I have purposely avoided the citation of cases because of the length of the paper which would result, but I cannot refrain from illustrating the danger from the douche by referring to two cases which came under my care about four years ago.

A young lady, aged 22, of excellent family and of spotless reputation, who for a long time had had a slight leucorrheal discharge, was advised by a girl friend to take douches. She loaned her own syringe, and instructed her in its use. Shortly thereafter my patient developed a very profuse leucorrhea, and on November 19, 1898, two and a half weeks later, I operated upon her for an exceedingly acute pyo-salpinx, which had ruptured into the general peritoneal cavity. She died on the day following the operation.

My patient's mother used this same syringe once, if I remember correctly, following a menstrual period and soon thereafter began to have pelvic pain and upon examination I was astonished to find an acute pyo-salpinx. I operated immediately upon her, on November 26, 1898, seven days after the operation upon her daughter, making a double tubo-ovariotomy. Both tubes were distended with pus. I have no doubt whatever but that both mother and daughter were infected by the use of the syringe which was loaned them by a friend who had suffered from an exceedingly virulent vaginal discharge.

The profession is now generally awakened to the dangers of conveying disease in ordinary office gynecological work, yet ideas differ as to the precautionary measures necessary to insure immunity. I wonder what proportion of the physicians who make vaginal examinations and local treatments in the office insist upon the boiling of the speculum, dressing forceps, and sound, (this latter instrument I trust they almost never use) before every case. Nothing short of this will insure against the possibility of conveying disease. Against the uterine sound I have a special antipathy. When a student in medicine I was instructed to

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use the instrument in nearly every examination to determine the position of the uterus and by feeling to ascertain the condition within the womb. Of late years I venture to say that I do not use this instrument once a year for purpose of examination or diagnosis; yet frequently employ it during operative procedure where there can be no objection to its use. It is an instrument capable of infinite damage. To pass it through an unsterilized region into the cavity of the uterus is to implant therein the germs of disease, and if they do not take root there it is due to good fortune rather than good judgment.

5. Surgery of the Fallopian Tubes.

Only a few years ago the feeling of the profession was strongly toward very radical operating in diseases of the uterus and adnexa. Five years ago the vaginal route was chosen for nearly all pelvic inflammatory diseases, and in cases of salpingitis the question then in vogue was, "What is the value of the uterus after the ovaries and tubes have been removed?" It is probably no more valuable this year than it was five years ago, yet very few operators will sacrifice it unless it is itself badly diseased. The ovaries were sacrificed if cystic, now they are resected, and if possible some portion preserved if no larger than a pea. A piece of the Fallopian tube is saved, if possible, even after the sacrifice of both ovaries, in the hope that menstruation will be continued. This tendency toward conservatism is truly commendable, but may be overdone to the extent of a complete failure as regards the cure of the patient. Last year a young woman who had had a previous abdominal operation in which her appendix and one ovary were removed, was operated upon a second time for a cystic ovary and a very tiny piece of ovarian tissue was left. We complimented ourselves upon the fact that a few years ago this young lady would doubtless have been unsexed. She made a good recovery from the operation, but in less than six months returned to the hospital with a cyst as large as a hen's-egg, which took its origin from the very small piece of ovary which was conserved. Five years ago this young woman would have had one laparotomy instead of three.

Five years ago I attempted to save a tube, the extremities of which had become sealed by an inflammatory process. A little fluid escaped from the tube, which was not thought at the time to be septic. The patient developed a septic peritonitis and died in a week's time. An autopsy showed a general peritonitis, which took its origin from the tube which I attempted to preserve. It was found to be gangrenous and resembled the slough of the vermiform appendix, such as I have washed from the cavity of an appendicial abscess.

I would not wish to convey the impression that I am not a firm believer in conservative treatment of the tubes and ovaries; the experiences

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cited demonstrate that I am. They illustrate also that it is not an easy question to determine the cases where it is policy to attempt to save or wisdom to remove.

In operation for salpingitis the abdominal route is to be preferred, because it allows a thorough investigation of the pathology and permits us to deal with the pelvic organs in the most conservative manner. In a chronic salpingitis following a pyosalpinx with a retroflexion of the uterus and prolapsus of ovaries and tubes, all of which have become firmly fixed by adhesive inflammation, the hand is introduced and a line of cleavage is usually easily discovered and the adherent tubes and ovaries can be separated from existing adhesions and brought into view. If the ovary is normal or affected only secondarily by the general pelvic inflammation, it is often possible to preserve it either as a whole or in part, while it may be necessary to sacrifice the tube.

If both ovaries must be removed then, when possible, a rather long pedicle to one amputated tube may be left. Do anything in fact which will tend to keep the woman menstruating. This rule applies especially to young women, where to bring about an artificial climacteric is often a source of great mental depression. If a woman but continue to menstruate she feels that she has not been unsexed. About ovulation she knows nothing and the medical profession are but little wiser.

In the removal of the tubes or ovaries, or both, in all septic conditions, it is important to use an absorbable ligature. If silk be used and any infection occurs the suture will not become encysted but remain as a constant source of irritation until thrown off.

In operating for pyosalpinx the abdominal route is to be preferred, and as soon as the abdomen is opened mops of gauze should be carefully inserted in such a manner as to wall-off the general peritoneal cavity to prevent infecting it should rupture of the tube occur during the operation. A large aspirator needle should next be introduced into the distended tube and its contents withdrawn. The operation is then identical with that for salpingitis, with the exception that in salpingitis one may usually close the abdomen without drainage, while in pyo-salpinx such a course is hazardous in the extreme. I am a firm believer in the gauze drain because it actually affords drainage and removes the fluid by capillary attraction, which is more than can be said in favor of tubular drainage. Again, I am afraid of the rubber drainage tube in the abdominal or pelvic cavity, as it is likely to be followed by a fecal fistula. This comes about by the end of the tube resting upon the wall of the intestine, which it may penetrate as the result of pressure-necrosis.

The gauze wick can be easily removed if we prevent its adherence to the abdominal incision. This is accomplished by carrying the wick of gauze through a rubber cylinder or finger-cot, which remains in contact

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with the incised wound. It serves another very important purpose, namely, to promote and facilitate capillary attraction. If the wick of gauze is not protected it will continue to drain only about twenty-four hours, when it becomes clogged at the side of the wound. If it is encased in the rubber cylinder it will continue to drain as long as fluid remains in the cavity and fresh dry gauze is in contact with the free end.

In pelvic abscess it is best to evacuate the pus *per vaginam* by making an incision through the vaginal vault posterior to the uterine artery. The position of this vessel can usually be determined by its pulsation, and it should be avoided. After the incision is made in the vaginal vault introduce the scissors and force them through the abscess wall; by separating the fingers and withdrawing the scissors the opening is dilated. A double drainage-tube is then introduced and the cavity flushed with an antiseptic solution. This tube is attached in position and the nurse instructed to syringe through the tube either once or twice a day, depending upon the amount of discharge and the general condition of the patient. After twelve or fourteen days the drainage-tube will work out and the discharge practically cease. But the patient is rarely cured by this operation. She is now in the most favorable condition for either tubo-ovariotomy by abdominal section or by vaginal hysterectomy, to have entire ablation of the pelvic organs.

Quite a number of cases are cured after the opening and drainage of a pelvic abscess *per vaginam,* but in the majority of cases acute relapses occur, or the adhesions which have formed occasion more or less constant pain and soreness in the pelvis, which can be relieved only by radical operation. This can be more safely performed in the interval than when the pelvis is filled with pus.

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CONSERVATISM IN MODERN GYNECOLOGICAL SURGERY

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Honoring the observance of custom it becomes my duty as Chairman of this Section to review the recent advances in gynecological practice. I do this with the double purpose of bringing them freshly to your minds, and being so recalled to make more pointed some inferences and conclusions warranted by the results of practice.

Some of the more important events are the following:

(*a*) *Beatson's Operation:* The removal of tubes and ovaries for recurrent mammary carcinoma.

Beatson's operation is restricted to recurrent mammary cancer of the breast only, and is of no value when the recurrence involves the axillary glands alone.

Theoretically its basis must rest upon some structural relation, or trophic connection, or upon the fact that the several organs concerned in reproduction are subject to modification, each by another, pathologically as well as physiologically. None of these bases are as yet very clearly defined in that direction, and further investigation was called for. This fact also must not be lost sight of, nor is it by any means new, that surgical procedures at distant points are known to arrest pathological processes of quite different kinds at other points. How far the principle employed is common to both also remains to be demonstrated. Practically, however, there have been many favorable reports upon it, although the time is yet too short to prove it to be a reliably efficient measure.

(*b*) *Ovarian Implantation:* This operation is meeting with some interesting results, not the least of which are those upon maternity. It is on record that in a number of instances pregnancy has occurred after double ovariotomy, when, it is believed, that a small amount of ovarian tissue has been left upon the distal side of the ligature. On like grounds it may be supposed to be possible to preserve the power of impregnation, provided that the graft is human and is properly located. But the most important result to be expected from the procedure is that of prevention or amelioration of the stormy symptoms so sure to follow the artificially induced menopause resulting from removal of both ovaries. There is, therefore, beyond the question of possible impregnation that of the preservation of the ovarian function and its influence upon uterine life, the fact of which appears to be a constant result. An enthusiastic

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gynecologist says: "The best result in ovarian grafting in my experience is the avoidance of the menopause. A summing up of the testimony of experimenters seems to indicate that a properly transplanted ovary may continue to perform its full normal function, and that we may not only expect to prevent the symptoms of the menopause after the patient's ovaries have been removed, but we may reasonably expect a pregnancy in a certain percentage of cases." It is to be pointed out, however, as has already been done by Prof. Clark, of the University of Pennsylvania, that some extraordinary social complications might arise on account of it.

Dr. A. Palmer Dudley, to whom we are mostly indebted for reliable statistics in respect to ovarian implantations, says that in those cases which he was able to keep track of—148 in number—137 are reported as cured and 11 as improved. From this 148 he is able to report 23 cases of pregnancy with delivery at full term, and 5 cases of miscarriage; in all 28 pregnancies, an average of about one in every five-and-a-half cases.

(*c*) *Cæsarean Section:* In the better practice this is being substituted for symphysiotomy, in cases of craniotomy, eclampsia and placenta previa centrally located. The better command of parts under the hand of the operator, the minimum injury to the tissues, and the greater conservatism of the whole procedure are sufficient reasons for the change.

(*d*) Baldy's operation for retro-displacement demands our attention. "With many, Alexander's operation, hysterroraphy and like procedures have been unsatisfactory. They have always more or less been associated with disadvantages, but the disadvantages have been accepted because we know nothing better to substitute."

This operation consists in severing the round ligaments close to their attachment to the uterus, puncturing the broad ligaments through which they are pulled "and the cut ends sutured to the cornua of the uterus on the posterior surface of the uterus directly back of the original point of attachment of the normally attached round ligament."

Perhaps a better operation than that of Dr. Clarence Webster, although the operation of Webster differs only in this, that in place of suturing the ends of the ligaments to the cornua he sutures the ends together and fastens the ligaments thus united to the posterior surface of the uterus.

The surgical treatment of tying the utero-sacral ligaments through the vagina in retroversion of the uterus, when the posterior vaginal wall is relaxed and the anterior vaginal wall short, is a late method for restoring the retro-displaced uterus, and may have some merit. Time will prove its benefits.

(*e*) The *abdominal,* or *vaginal route:* It is the same much dis-

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cussed question, but with decided tendency to fix upon the abdominal as the safest, except in view of special conditions; as in pyosalpinx of one or both tubes and in some cases of hysterectomy.

(*f*) *Appendicitis:* There is decidedly less cutting. Statistics show that without operative interference 80 per cent get well, while only 20 per cent die. It may be expected, of course, that the latter number may be reduced by surgical measures, but the comparative mortality among these must be great.

(*g*) The operation of anastomosing the portal veins with the systemic veins by suturing the omentum to the parietal peritoneum. Though not strictly germane to gynecological surgery, yet I cannot forbear to allude to the operation which has brought relief and prolonged the lives of those who have suffered from ascites, the result of cirrhosis of the liver. It is not claimed that the cirrhotic condition is thus cured, but it is certain that in most instances the ascites and other annoying symptoms may be greatly, if not permanently, relieved thereby.

Conservatism is the striking feature in all of these improved methods; conservatism in technique, in instrumentation, in lines of limitation between operable and inoperable cases, in ante and post-operative management, in the admission into the armamentarium of bloodless means, and all to conserve the strength and safety and recovery of the patient, and not, if there unhappily be any such, to kindle the growing or enhance an established surgical reputation. A retrospect of the last decade, and especially of the last twelve months, shows a decided tendency to conservatism, particularly in surgical-gynecological work, as was predicted by the conscientious surgeon and the physician-surgeon. Does it not require "a higher order of ability, and is it not a truer and nobler triumph of our art, to save an organ or part of an organ than to destroy it by sacrificial surgery?"

It has been the belief of too many surgeon-gynecologists that the removal of the diseased organ restores to health; but continued invalidism after such removal, which may be even worse than before, brings to the front some very serious propositions the answers to which are convincing enough that such measures are but too often dealing merely with results of the disease, while the causes remain active as before. Some of us are therefore convinced that such removable results are often mere passive elements in a complexity of far wider range; or, indeed, they may be of themselves conservative elements of the most patent character. The knife cannot be the materia medica; its diagnostic powers do not reach beyond its point; cure begins where its power ends. We must not be unmindful that the conservative surgery includes any or all methods of treatment that may restore to health, with always the more radical measure at hand. But it does not lead. Nor must we forget that

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whether the knife leads or follows after, carefully chosen medical treatment has frequently completely restored the health when surgical measures have failed to benefit. These are not irresponsible statements—both time and place preclude that, but can be and have been verified over and over by many of our representative gynecologists. Restoration to health without the use of the knife is of itself proof of profound knowledge of disease; but to know when *not* to use it, and *why* not, and that there are other and better means, is proof of a profounder knowledge still.

The following, quoted from an eminent writer, is a true and too frequent verdict to be written upon indiscriminate surgical practice: "That the result of the operation was not the success expected by the patient and anticipated by the operator was due neither to lack of skill on the part of the surgeon nor to any fault of the patient; but the fact remains that the sufferer is far removed from being cured."

Now, let us consider why it is that there is so much morbidity, or failure to recover, following surgical operations?

(*a*) There is not a thorough diagnosis of the case, nor is the cause and course of the disease ascertained.

(*b*) The therapeutical nihilism so prevalent among younger surgeons, as well as pro-surgical gynecologists.

One of the ablest surgeons of the old school says "that the perfected operative treatment of modern surgery has taken the place of all treatment, both with drugs and electricity."

(*c*) The faults of patients, some of whom will not accept advice because they will not take the time and submit to the self-denials necessary to a cure. This is too often true of the patient who declines to be restricted in her fashionable social functions, who will not; and in the poor woman whose domestic and marital duties make such demands upon her strength, who cannot. Both have been promised relief by the surgeon-gynecologist, and both have believed and both have failed.

It seems needless to specify among the large number of procedures, further than to illustrate the true position of affairs, which the following may do: "It has been the almost universal custom among the gynecologists to remove all diseased tubes whether they contain accumulations of pus from gonorrhea, puerperal infection or otherwise, or where thickened and bound down by adhesions.

"This statement from an experienced operator, covering so wide a ground, followed by severe strictures upon indiscriminating operations, should teach the less experienced a valuable practical lesson. Many operators now realize that the results of certain operations are disappointing, and the relief of subjective symptoms is far from satisfactory. Fritsch declares that fully 33 per cent of patients upon whom lapa-

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rotomy had been performed for the relief of pyosalpinx were not in the least benefited, and that it was the most unsatisfactory operation which the modern gynecologist performed.

"These unsatisfactory results have led the French and some Americans to adopt the still more radical operation of removing the uterus as well as the appendages. But in this also it has been found that not only do these patients often suffer from a return of their old symptoms after operation, but if at the time the ovaries were removed, distressing symptoms of the artificially induced menopause which invariably runs a stormy course, lasting from one to several years, become prominent, the whole constituting a picture from which any operator may well draw back, but which is, unfortunately, too familiar."

The same is true of the removal of ovaries for certain forms of disease not necessary to enumerate, and of many curettages and of plastic work upon the cervix and pelvic floor. Many of us have unnecessarily and unfortunately removed ovaries for cystic degeneration when, if we had been conservative, these organs could have been saved, for of 97 cases of cystic degeneration of the ovaries treated conservatively by resection and ignipuncture 10 pregnancies followed.

It must not be understood that I do not approve of nor make these operations. Among them all I have done many that have resulted most favorably. But there can be no doubt that we have been too radical in condemning such organs to removal, and have given too much assurance that many of our plastic operations were all that were required to insure return to complete and perfect health.

Therefore, we may add yet stronger emphasis to the fact that, the work well done, post-operative morbidity is proof positive that the removal of results of disease does not remove the cause.

What courses are open for our guidance and protection? How may operations, at least doubtful ones, be averted or done? How may succeeding morbidity be lessened?

(*a*) Before operation, become thoroughly acquainted with the character and tendency of the disease, with the history of the patient and family, especially with reference to hereditary and acquired predispositions.

(*b*) If any doubt exists as to perfect convalescence after operation, first make use of all approved remedial and adjuvant measures before resorting to it.

(*c*) At no time let it be forgotten that many, after such operations, indeed, on account of them, are now suffering not only from hopeless invalidism, but from melancholia and mental disturbances, and even permanent insanity.

The preparation of the patient may be all that could be desired,

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the operation skillfully and brilliantly performed, the technique and links in the antiseptic chain perfect in detail, the convalescence uninterrupted, and it goes on record that the patient was discharged from the hospital cured, and so regarded as a triumph for modern surgery. But wait a little; the patient returns for advice upon her condition; she has not improved; in fact, is worse than before the operation. This is a truthful picture and has doubtless been the experience of all of us; but none the less does it place us in an uncomfortable position, and all the more do we feel that it is imperative that we so act as to prevent such occurrences, or make them more and more infrequent or remote.

Do we not too often regard organs as pathologically changed to a serious extent, when the conditions are no more than congestion and infiltration of their walls? Too often regard tubes containing pus, and ovaries the seat of abscess with adhesions and therefore indicating radical measures, as being the seats of irrecoverable disease, when in reality there are no structural changes, and therefore the case is within the scope of medicinal or other than surgical treatment? Have we not been too ready to condemn these appendages? Suppose that we do find pus in the tubes and ovaries; have we so soon forgotten the surgical principle that nature circumscribes these infected foci, that their virulence dies out and they thus become benign and harmless? An exception to this is found in accumulations from gonorrheal infection, which is both virulent and specific. But in this exceptional case, why is so much reliance placed upon early and absolute removal when it is in fact well known that it is practically impossible to include all invaded tissues? Is it again forgotten that pathology teaches that one of the channels for the distribution of gonocci to tubes and ovaries is through lymphatics of the broad ligaments, and these through absorption from the vaginal walls? What, then, is the possible gain in the removal of tubes and ovaries, leaving still infected tissue behind? This much may be taken for granted at the outset, and characterizes every case of length of standing: that infection of lymphatic glands has proceeded further than may be reached by the surgeon's knife. This is the point from which every surgical judgment in these cases should invariably proceed. It may be stated as a general commentary on the whole subject, the remark of Zweifel that only 4 per cent of attacks of pelvic inflammation ever reach the stage of suppuration.

I have already referred incidentally to constitutional conditions as causes of many uterine disorders, of their facility in assuming controlling positions in a complex of both local and general symptoms, and now I desire to add especial emphasis to their responsibility as stumbling blocks in the way of the recoveries we have so confidently hoped for and predicted. The assertion is ventured that in large num-

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bers of cases of so-called recurrence of pelvic disease or its so-called transference to contiguous organs, or mere continued invalidism, all presenting themselves after apparently well-indicated surgical procedures, are local expressions of constitutional disease—that is, some systemic function, as that of metabolism, the blood-making or tissue-transforming powers, any one or all the fault of which may degrade or destroy the equilibrium of the whole, has so manifested itself, or by an equivalent, until in itself it is cured, all means for local cure to the contrary notwithstanding.

There is yet another disease to which I ask your attention—fibroid tumors of the uterus, or *fibrosis,* more properly speaking, and the operations upon them, myomectomy and hystero-myomectomy. The operations are yet young, too young to have fixed upon them any very definable limitations of conservative surgery. Fibrosis itself is yet young in a fully realized constitutional sense, too young to have definitely fixed upon it the responsibility for characteristic recurrences and repeated operations so frequent and so discouraging to surgeons. Let the pathologist of to-day point out the way very precisely in the characteristic cell degenerations of the disease, in the ease with which it disseminates itself among the organs of the body other than the uterus, and in its metastatic tendency; so that in given cases apparent radicalism is really the most careful conservatism. Fibrosis is not, *per se,* a disease of the uterus. It is a constitutional, or nutritional, disease with pelvic localization. Constitutional limitations, therefore, in everything except the mechanical sense, become the limitations of conservative surgical procedures upon it.

It would seem, then, no longer doubtful (and why not doubtful?) that the removal of one or more fibroid tumors from the uterus may be, is likely to be, followed by the development of others which may be of more virulent or semi-malignant character than before. A painstaking and scientific gynecologist says: "After examining microscopically several hundred specimens, that myomectomy should be an exceptional operation for the reason that in a great majority of cases these tumors were extraordinarily multiple in their development, some showing fifty or even one hundred different centers of development." My own experience coincides with this statement.

"Another writer states that, after careful and long-continued microscopical study of sections of fibroid uteri, it has been clearly demonstrated that where there is a myo-fibroma, not only is the uterus diseased, but that it is this disease that produces the fibroid growths. The tissues of the uterus are first reduced to granular or medullary tissue, and from this fibroid tumors are developed. A new growth can only come by some tissue being reduced to its primal elements. In every case ex-

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amined the cervix has been most profoundly diseased and has shown most advanced pathological changes."

Now, in view of all of the foregoing considerations, can we do otherwise than insist that the treatment of every case of fibroid disease must be undertaken first from the constitutional point of view, and that every instance of surgical intervention be undertaken upon the same and therefore conservative basis?

Let us now assume the necessity for operative measures. When is it best to operate? Among the most eminent there are wide differences of opinion. Some maintain that at the inception of the growth, or on its discovery, is better, because of less risk, and before the system is impaired by its presence and weight. Others advise postponement until resulting constitutional disturbances are in evidence, and that the risks of operation are no greater at this time than earlier. In reaching conclusions it is not to be forgotten that cures have been effected by medicines and adjuvants, by electrolysis, that such growths have spontaneously disappeared, and that some have remained *in situ*, latent, without inconvenience, to old age, death occurring from other causes. Except in exigencies, therefore, the less radical measures must have been given fair trial.

However, it is generally conceded that there are conditions that demand immediate removal surgically, and are as follows:

(*a*) Degeneration is suspected.

(*b*) Sudden development at climacterium.

(*c*) When so large as to threaten life by pressure on abdominal organs and the diaphragm.

(*d*) When anuria, from pressure on the ureters by hydro-ureter, hydro-nephrosis, pyelo-nephrosis, serious neuralgia, dysuria, ischuria paradoxa, and coprostastis exist.

(*e*) Menorrhagia and metrorrhagia.

(*f*) Obstacles to child-bearing.

I cannot at this time enter fully upon a discussion of the relative merits of the two operations, myomectomy and hystero-myomectomy. This, in general, is my position, that up to, and after the child-bearing age, all things equal, diathesis, clinical history, and local conditions coinciding, the latter is in my judgment the preferable operation. True, it is classed as radical, but the disease as a whole taken into account, it undoubtedly is the more conservative, and therefore to be preferred.

The following brief differentiations may throw some light upon the matter of choice:

(*a*) There is no operation within the whole domain of surgery that requires more careful deliberation than myomectomy, because of the great number of possible complications and relative issues connected with it.

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(*b*) There is greater comparative risk from sepsis in myomectomy from mere handling of the tissues which have to be dropped back into the abdomen.

(*c*) Hemorrhage in myomectomy is more difficult to control. In hystero-myomectomy this is practically assured when the four main arteries are secured, which is more readily and safely accomplished.

(*d*) Myomectomy is more dangerous than hystero-myomectomy because it demands greater care in each step of the technique. Inadvertencies may prove fatal.

(*e*) And it is more dangerous because in such case both it and the operation must be strictly individualized. In hystero-myomectomy the operation has assumed more or less of a routine character.

Myomectomy is an operation of election within definable limits. It conserves a natural function and guarantees the possibility of conception and motherhood, which have followed the operation, all of which should give it a high standing in the estimation of surgeon-gynecologists. But when the uterine tissues have the ends of fibrosis scattered through them, when the constitutional predisposition is so clearly marked as to render extension of the disease a forgone conclusion, I cannot believe it to be an admissible operation because of the double certainty of recurrence, and because if thoroughly done the walls of the uterus must be so weakened that pregnancy would increase the liability to rupture. If not thoroughly done it sinks to the level of a mere palliative, certain to be repeated, or, worse, it proves to be a spur to more rapid development, to increased virulence, or even malignancy.

However, admittedly it may be resorted to:

(*a*) When the level of the myomatous uterus is below the umbilicus.

(*b*) When assurance is felt that after the removal of the tumor or tumors the uterus will be restored to a healthful state.

(*c*) When the patient is under thirty-seven years of age, or during the child-bearing period.

Hystero-myomectomy is preferable:

(*a*) When the patient is past the child-bearing age.

(*b*) When disease of tubes or ovaries makes conservatism of the uterus useless.

(*c*) When exhaustion from hemorrhage makes it imperative that the operation be completed as soon as possible.

Regarding treatment other than surgical, much might be profitably said, but we must be content with a few hints. After a quarter of a century with a wide field of observation and large experience, I am convinced that where certain characteristics are presented, proper internal

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medication, ozone and other vaginal sprays, medicated tampons, and intelligent and skillful application of electrolysis have not only relieved suffering and arrested the development of growths, but in some instances have dispersed them or promoted their absorption.

I would especially note the value of the concurrent local and internal use of a carefully-chosen constitutional remedy.

The following have proved beneficial, and are confidently recommended: *Ergot, ustilago, calcarea iod., and hydrastis.*

These remedies are worthy of special notice because of their specific character, and their action from both directions, local and general.

In particular, the physiological action of *ergot* should be kept up until the arterials are sufficiently contracted and the muscular coats so shortened as to impair the nutrition of the tumor, when it dies of starvation. *Ustilago,* a drug of much the same character, may be used in the same manner. *Iodide-of-lime* is indicated in all phases and conditions, on account of its powerful effect upon nutrition. *Hydrastis* is the tonic *par excellence.*

DISCUSSION:

DR. C. E. SAWYER: It is a matter of professional gratification to have the opportunity of reviewing the marked advances in gynecological practice during the past year and it is certainly a great privilege to learn of them in the able and masterly way in which they have just been presented by the Chairman of this Section.

Beatson's Operation.—It is true that the effect of Beatson's operation is, up to the present time, largely theoretical. It is likewise true that the mammary glands are an integral part of the female generative system, and the relation between them and the uterus with its tubes and ovaries is most intimate. In their union they constitute one of the special systems of the body, and the action and re-action which plays between the parts of so important a system is very great, and the influence of an operation on one part of this system can but make important changes in other organs belonging to it, not only directly but indirectly. Directly, by removal of the ovaries, because that brings on the menopause. Indirectly, because it changes the nerve-supply, and consequently the blood-supply to the whole generative system, thereby modifying and correcting disturbances which would otherwise remain unchanged; another proof of the fact that the medical profession has not yet learned to fully appreciate the law of reflexes, and the great restorative power of the human body.

Ovarian Implantation.—Referring to ovarian implantation, we have another lesson of the far-reaching effect in the same direction as in Beatson's operation, and we must all sooner or later agree that we should pay greater deference to nervous influences and the laws governing them in dealing with these important parts of female anatomy.

Cæsarean.—Cæsarean section, as compared with symphysiotomy, speaks for itself.

Abdominal or Vaginal Route.—The abdominal or vaginal route, in

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my opinion, is a question for personal settlement in every case. There can certainly be no fixed or fast rules either for the one or against the other; the surgeon's judgment must always indicate the course of procedure. In one case nothing but the advantage of the open inspection of laparotomy will do, while in another the possibilities of the vaginal route are all-sufficient.

Appendicitis.—The statistics given in the treatment of appendicitis without operative interference demonstrate that here too there is a medium ground which nothing but the practical experience, close observation and inherent instinct of the operator is capable of determining; another necessity of individualization, of careful investigation and of sober judgment; a lesson demonstrating also that the same means in the hands of one individual are more efficient than in that of another, and one of the all-important questions which each gynecological surgeon must determine is his own skillfulness in the means to be employed.

I do not believe that all men can prescribe or operate alike, and each should know his own ability, and be governed entirely by that ability in what he does. I heartily agree with Dr. Biggar in his policies of conservatism regarding the removal of organs and the absolute destruction of tissues. The surgeon of the future will be recognized not by the amount of cutting he can do, not by the large amount of tissues he may remove, but rather by what he saves. No organ of the body in life is without its purpose and place, and that place is always in keeping with the performance of such part of its function as it may be capable of doing, and nothing but the most extreme condition should ever demand radical methods, and then only when the more conservative ones have first been employed. Many an ovary has been sacrificed without pathological justification because it was easier for the surgeon himself.

When gynecologists have learned that the smallest part of the generative system left intact is by far better than none at all, he will have attained his greatest degree of usefulness and much that is now practice will have become obsolete and relegated to the list of past and inferior methods.

There are two things which must be taken into consideration in every case. *First*, the question of cause. *Second*, the *tout ensemble* of the case. No fixed law can be laid down for any class of cases. The judgment of experience as to what shall be done under certain conditions is the only safe guide. The gynecological surgeon who is capable by education, by experience, by a knowledge of homœopathic medication, and, above all else, by intuition, to differentiate cases, is the gynecologist who succeeds best. Theorists and philosophers count but for little as against practicability and instinctive foresight.

So far it has been easy to agree with the tenor of Dr. Biggar's paper, but when we come to the consideration of the course of procedure in the handling of fibroid growths, I take issue with the Doctor when he advises myo-hysterectomy in preference to myomectomy. I do not believe myomatous tumors can be regarded as constitutional. First, because they are never observed as a congenital tumor but are always the result of some exciting tissue-proliferation, such as menstruation and child-bearing, and only arise as a localized condition, and are not known to occur as a metastatic consequence.

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In 528 cases collected by Chiara, West, Brigle, Schroeder and Winckel there was no case under ten years of age. Eighteen per cent had occurred between the ages of 20 and 30. Three per cent between the ages of 20 and 25, and all under forty years of age. Senn says "that it is safe to assume that a large majority of the cases of fibroid tumors appear in the latter part of the third and the beginning of the fourth decennium," and they are always due to the exciting causes above enumerated.

Admitting that they are often multiple and that they may possibly recur, which latter, by the way, is contrary to all of the evidence at hand, I still contend that it is poor surgery to adopt only the most radical methods in their treatment.

If they are multiple, it is not a much more difficult matter to extract any number than it is to remove one; they are, after all, only barnacles on the ship's hull, and it is certainly not necessary to destroy the whole ship to again clear it for action; and if they should recur it is not impossible to remove them again. In my opinion it is far better to do a second operation than it is to leave the individual with all the risks and liabilities that come from complete ablation of the organs. Dr. Biggar has already admitted that many cases that have been submitted to the heroism of pan-hysterectomy have been left "worse off" than before, and he has admonished us to "let it at no time be forgotten that many, after such operations, indeed on account of them, are now suffering from not only hopeless invalidism, but from melancholia and mental disturbances and even permanent insanity."

If such are the chances, why should the more radical myo-hysterectomy be preferred to the more conservative myomectomy?

If conservatism were not possible, how could Apostoli have made such a record by electrolysis, Pean, with *morcellement,* and hundreds of our professional brethren by the indicated remedy and similar lines of conservative treatment?

Again, referring to Senn, in speaking of complete hysterectomy he says, "The best surgery is always conservative surgery. In operations for benign tumors, healthy organs or parts of healthy organs should not be sacrificed unnecessarily." He also says "that laparo-hysterectomy has been performed too frequently in the treatment of myo-fibromata." While Kelly, whose experience entitles his opinion to deference, states under headlines emphasized by capital letters "that myomectomy within the proper age-limit must always be the operation of election," on the same page under the title of myomectomy he asserts "that abdominal myomectomy is one of the most actively conservative of all operative procedures."

With this evidence presenting, which by the way is but a small part of what might be produced, I for my own part wish to go on record as favoring myomectomy as compared with pan-hysterectomy in every case.

I had rather be responsible for the errors of omission than commission, and I take this occasion of predicting that the future has in store a record for myomectomy which will prove its superiority.

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THE TREATMENTS FOR UTERINE FIBROIDS

E. Stillman Bailey, M. D.
CHICAGO

I am reporting one hundred and two cases of uterine fibroids under various treatments.

I have treated twenty-six cases of uterine fibroid with galvanism. I am frank to say in the beginning that the personal influence of Dr. Apostoli, of Paris, awakened in me a desire to treat fibroids with the methods which he promulgated, and after serving several weeks with him in the clinic I became enthusiastic in this form of treatment. I used his technique, so need say no more concerning it.

Of these twenty-six cases, since undertaking their treatment with electricity, I have abandoned five of them and operated, believing this method to be better than the continuation of the electric treatment. Ten other cases at the present time have passed out of my notice, so I cannot report positively of results, but at the time of the suspension of the treatment there had been a marked improvement, so I feel justified in presenting these ten as being benefited by the treatment; whether it was lasting or not I am unable to say. Of the remaining eleven cases two have died—one of uterine cancer, the other of consumption. The other nine cases are known to me at the present time, and are entirely well. Five of them I have seen recently, four I occasionally hear from through correspondence.

This, I know, is by no means a report upon which to base conclusions as to the merits of the tretment; still I remain much in favor of the treatment for a certain class of fibroids. Those under my care that have responded best to treatment have been:

1st. The single myomas of the intra-mural variety.

2nd. Those tumors that had persistent hemorrhages as the characteristic.

So far as my notes show, the most successful cases under galvanism were the tumors of medium size and occurring in women prior to any influences connected with the change of life. I have noted some forms of relief, as well as some forms of cure, that make me partial to this line of treatment.

In the second division I place thirty-three cases of hysterectomies for fibroids, with a loss of three cases. Twenty-one were abdominal and twelve vaginal.

In the third division, I have under observation at the present time

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forty-three cases diagnosed as fibroid tumors, and it is concerning this class that I am most interested at the present writing.

Of these patients there are several who have absolutely refused operative measures. There are others in this class that are willing to submit to any form of experiment rather than to have the knife as the first method of treatment. There are some others whose tumors would present such difficulties as to make it almost impossible to remove the same; and while at the present time they are enjoying a fairly comfortable existence, the argument is that they do not care to be disturbed with a more serious form of treatment.

First observation: More than one-half (23) of the cases in this class are at the present time under the treatment for the fibroids by the use of thyroidin. (Thyroidin 1x tablet, 15 grains daily, as the maximum dose.) Concerning this remedy, in a paper that I presented to the *Clinical Society of Hahnemann Hospital* five years ago, I made a report of cases that seemed cured. As a result of the publishing of a report of the cases using this remedy for two consecutive years, I became acquainted with a good many of the fibroid cases that were being treated by physicians outside of the city, and am in correspondence with them regarding these cases. I am surprised at the uniformly good results where the patients were faithful in the use of this remedy. By faithful I mean the continued use of this remedy week after week and month after month. I wish to emphasize the good results of the long-continued use of this remedy. In some instances favorable results seemed to appear early on its exhibition. In other instances it must be persevered in to be of any value whatever. Its sphere of action, as I observed it, seems to consist in doing away with the density or hardness of the tumor. In one case of sub-peritoneal fibroid the growth could easily be felt and manipulated; there seemed to be an entire shrinkage of the growth. While I do not say it disappeared entirely, anatomically speaking, still it became so slight as compared with its former size that the patient gave up using the remedy more than a year ago, and since then there has been no return or indication of a return of the growth.

The class of patients to whom I have given the thyroidin are those known to have fibroids and at the same time declare they are entirely free from distressing symptoms. There being no necessity for operating to relieve pressure-symptoms or troublesome hemorrhages, the location of the tumor giving little or no inconvenience, I have administered this remedy with confidence, and present it as one having merit. A few in this class have been troubled with severe uterine hemorrhages. Before undertaking any more serious operation I have almost invariably performed the curettement, and it is my experience that many of these cases of fibroids are complicated with endometritis and that the real

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cause for the bleeding rests in the diseased state of the endometrium rather than in the presence of the fibroid.

The truth of this proposition is forced upon me by an observation where a patient had had a uterine hemorrhage of a severe character which lasted almost continuously for two months. The tumor was of enormous size, fixed in the pelvis, and for years had been let entirely alone locally, being classed as inoperable. The repeated hemorrhages, supposedly from the fibroid, produced profound anemia.

I dilated the uterus, under Schleick's solution of cocaine, and thoroughly curetted, the hemorrhage ceasing the next day and the patient making a fine recovery. Several months having now intervened since this operation was performed, and no hemorrhage has repeated itself, I am led to believe that in the management of fibroids with hemorrhages very much can be done by the treatment of the endometrium. I am also inclined to believe, as a prophylactic treatment, that these patients should not be allowed to lose much blood, and therefore I urge that the curettement be performed as a prophylactic measure in the early history of the treatment of fibroids.

In this class of cases I have also had occasion to notice that a few of them have materially decreased in size since they were first discovered. Three such cases presented themselves to me, stating that they were positive the growth had appeared very suddenly and it had reached its present large proportions very rapidly, and because of this rapidity they had been advised to have the growth removed without delay. No other immediate symptom except that of size presenting itself, upon promise of allowing frequent observation I have seen these three people get well. The growth disappeared slowly, but at the same time operative interference was avoided and the parts restored to their usual health. These cases, few as they are, seem to warrant me at least in putting off the early surgical interference.

Another class of cases that are in this list—that of treated rather than operated—belong to those whose age is about the change of life. The size of the tumor does not seem to be of any particular consideration. If she experienced no considerable inconvenience from the presence of the growth, my experience would lead me, if possible, to carry her through this climacteric period; first, because it is possible that the climacteric in a certain way influences these growths, and, secondly, the surgical methods at this time seem to produce very serious nervous symptoms. If the patient can be tided over a greater degree by non-surgical methods, I think it is always in the interest of the case to do so. The remedy I have used has been *Hamamelis* internally in appreciable doses, a tablespoonful of the extract; repeat often, and continue for many days.

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Notwithstanding the denial made by a number of gynecologists that these growths do not diminish after the menopause, it is nevertheless a law that after the menopause they do undergo retrograde metamorphosis. The cases contradictory to the law are really very rare. On the other hand, in some of my cases I have felt that the menopause had been much prolonged and the patient kept in a mental and physical condition of unrest on account of the presence of the fibroid and the returning menstrual cycle. It is my contention, however, that with such aids as we can bring to bear upon these cases, such as internal medication, *Hydrastis* and *China* as the type, curettement, or the packing the cavity of the womb, that the changes at the menopause can be hastened, and without danger to the patient.

In this class of cases I am fully convinced that Schroeder's opinion is of great value, where he says that when the myomas begin to develop at or after the time of the menopause it is due to the circumstance that they are nourished by extensive adhesions to the omentum and intestines. This fact accounts for the continued enlargement of myomas in such cases as have had repeated attacks of peritonitis, the tumor growing from material stolen through the new-formed adhesions and new-made blood supplies.

I am also reminded of a class of cases where the myomas were discovered and had considerable local treatment, after which conception took place, and the problem was that of destroying the fetus or destroying the tumor and fetus. In two cases under my care I am happy to state that the pregnancy was the means of doing away with the tumors. In one case the patient is the mother of three children; in the other the patient is the mother of one child. The labors were not especially difficult, and the fact remains that the fibroids have disappeared.

In a certain number of cases I have been puzzled to know the meaning of a leucorrheal discharge. Now, in treatment by galvanism, the active pole being negative, and inserted into the cavity of the uterus, it is a part of the treatment to watch for a copious watery discharge, which is apt to set in immediately after galvanism, and may last several days. This is regarded as a favorable sign, as the watery discharge is from the tissues harboring the fibroid, or from the fibroid itself. Almost invariably with the watery discharge the tumor grows smaller and softer. If the leucorrhea is of this character it can be encouraged to the advantage of the patient, but if it takes on the character of infection with pus or the element of destruction, it furnishes almost positive evidence that operative interference is a necessity.

One other observation, and that is the presence or absence of pain. While this question would be too long to discuss as to the cause of pain, I believe it can be answered that it is oftenest produced by the incar-

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ceration of the myoma in the pelvis-producing symptoms of ischuria or pressure-symptoms that can be traced to the ovaries or rectum. In many cases the absence of pain seems to be the rule, and I am not sure that the time will not come when the question of pain alone will be one of the greatest arguments favoring operative treatment, if it is not already so. When myomas are complicated with cystic changes electric treatment is contra-indicated and operative interference is necessary.

In conclusion I confess a willingness and a desire to save my patients from operative measures, and in my work for the past fifteen years in dealing with these few cases I am happy to say that in this list over twenty cases have been thoroughly cured without operative interference. I remember to have been prejudiced in this especial line of work by a line from Virchow, the great pathologist, when he says, "After all, the principle must be kept in mind that a myoma is an entirely local formation, in itself benign, which brings to the body no other danger than that which is determined by its local effects and changes." I have also been persuaded by those, the statement of whose opportunities for observation have been very extensive, that unless tumors by their presence cause distress, that treatment before surgical interference is warranted.

SUMMARY OF THIS REPORT.

Twenty-six cases treated by galvanism: Nine cured; supposed to be improved, 10; failures, 5.

Thirty-three cases of surgical operations; being twenty-one abdominal hysterectomies, twelve vaginal hysterectomies: Three deaths. Three by the abdominal method. None by the vaginal.

Forty-three cases under treatment; twenty-three under thyroidin; continued from one to seven years under observation and remain non-surgical. Twenty more recent cases scattered so that I cannot report as to the exact present condition, but improvement in many particulars was the last report. None considered surgical.

DISCUSSION:

J. M. LEE, M. D.: Mr. Chairman, Ladies and Gentlemen: I did not have the pleasure of seeing this paper prior to the reading, and I did not hear all of it read, therefore I am not going to make any effort to discuss it in detail. I merely call attention to the fact that fibroid tumors atrophy and disappear during the period of sexual activity and during the period which immediately follows the menopause, and, therefore, it is impossible for any one to tell whether his treatment has been the cause of the disappearance of the growth, or whether it is due to nature. The Doctor speaks of the growths remaining harmless during pregnancy and that after the parturient period they disappear. This is also true; but while you find one case of that kind, you will find seventy-five which take on rapid growth during the stage of gestation; and

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in some of these, the patient's life is terminated at or before parturition. In other instances where there are many growths present during gestation an abdominal section may be made, the tumors enucleated, even going down to the mucous membrane, and the patient recover without any disturbance of gestation, and finally be delivered at full term. I have no objection to the employment of palliative measures. In fact, if the tumor is not of such a character as to give pain, hemorrhage, or some of the other distressing symptoms mentioned, it is quite the proper thing to do. But, mind you, ladies and gentlemen, you must not employ those means which were advocated a few years ago, especially the introduction of needles and the application of the electric current, because in this treatment you have a method which is quite as likely to terminate life as an appropriate operation for the complete relief of the patient. Do not use ergot hypodermically. Do not use anything which will cause adhesions and spoil the case for surgical treatment. Now, in the use of all these remedies, you must remember that while the patient is liable to be so fortunate as to have atrophy or calcareous degenerations develop, there is also danger, and great danger too, from malignant degeneration, chiefly of a sarcomatous character, though carcinomatous transformation sometimes occurs.

So then, I want to warn you in the application of all these so-called curative or palliative means to be careful, to be watchful, that in your treatment you do not do more harm than good. Now, Doctor, will you be so kind as to tell me how many cases were operated upon and about what per cent recevered?

Dr. E. S. Bailey: Thirty-three cases were operated upon; three cases were lost.

Dr. J. M. Lee: The Doctor's operative treatment began early when extra-peritoneal treatment of the pedicle was in vogue. He had in the neighborhood of thirty-three cases; out of these he lost three; so you see his mortality was only twelve per cent. Only a few years ago the mortality was sixty per cent. This shows what a marvelous change for the better has come about. And if Dr. Bailey would give the results of his later cases alone, treated by our modern methods, I have no doubt but that his death rate would be reduced to five per cent. We are to be congratulated for this surgical improvement, especially for such men as the Doctor, who has helped to bring this mortality down.

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TREATMENT OF UTERINE DISPLACEMENTS

DeWitt G. Wilcox, M. D.
BUFFALO

Notwithstanding the amount written and expressed relative to uterine displacements, there remains always a further word to be added. My paper is more for the purpose of adding this additional word than an exhaustive treatment of the subject. Why are our American women to-day suffering so generally with uterine displacements? This is a question which the obstetric and gynecologic surgeon must endeavor to answer. As our American women are rapidly losing their old-time prestige as mothers of large families, we cannot charge frequent pregnancies as being the chief causative factor in the production of uterine displacement in her case.

We do know that a uterus normal in size is rarely displaced, and still more infrequently prolapsed. We know still further that an inflamed, enlarged and subinvoluted uterus has taken the first step toward a displacement, and that such a uterus only awaits a certain number of accompanying conditions to render the track clear for a complete procidentia or exaggerated retro-displacement. Hence, if we can find the cause producing an enlarged uterus, we have made a move in solving the above propounded question. Frequent abortions are much more prone to leave a uterus sub-involuted than are an equal number of normal pregnancies. This is for many reasons: *First,* the patient is not likely to receive as careful attention following an abortion as she is after labor; frequently she assumes the care of her own case, as she is ashamed or afraid to call her physician, consequently she gets up too soon and the uterus has not had the full opportunity to become involuted. *Second,* it is a pathological condition, and nature is not fully prepared to begin at once the reparative process such as follows a normal confinement. Hence, the muscle-cell degeneration and atrophy which produced the rapid and complete contraction of the uterus following normal labor is here absent, and an enlarged uterus forever remains. Again, the continued and prolonged practice of preventing conception is quite likely to lead to a chronic congestion of the uterus, and thus lay the foundation for a displacement. Thus does the woman who escapes the duty of bearing children, through design or misfortune, render herself liable to that painful and pitiful state of semi-invalidism, resulting from uterine displacement.

While the majority of cases of uterine displacement occur in women

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who have borne children, yet a certain percentage of these cases could be averted by a little timely and skillful attention given them at the early stage of the disorder. Given, a woman who has an enlarged uterus, whether through chronic inflammation or sub-involution, and we have a patient who has a goodly start toward a retro-displacement. Sooner or later, the long, heavy fundus which crowds its way up high in the pelvis will be pushed over backward and forced downward because of the intra-abdominal pressure. The uterine ligaments have been supporting this over-weighted uterus for months, and now they begin to weaken and allow the uterus to settle. If there be added a constipated habit, the pressure within is increased and ere long the fundus is well settled into the hollow of the sacrum. If any infection should now find its way through the tubes and even a slight peritonitis occur, there will in all probability result certain adhesions which tend to hold this displaced fundus firmly in its unnatural position. To the average woman such a condition can result only in constant discomfort, nervous irritability, reflex irritation and ultimate semi-invalidism.

Again, starting with an enlarged uterus, over-stretched ligaments, intra-abdominal pressure and a constipated habit, we have all the conditions ready for the beginning of a prolapse. If, unlike the former case, we have a torn or relaxed perineum, a long conical cervix, and an occupation which keeps the patient long upon her feet, there is nothing but the abolition of the law of gravitation which will prevent a complete procidentia.

What, then, can we do to prevent the occurrence of these displacements? And how can we cure them after they occur? are the practical questions which present themselves to us. If an enlarged uterus is the first requirement of a displacement, obviously, our task begins in seeking to prevent such enlargement; or, finding that it has already occurred, to employ the best means of reducing it to a normal size before it has begun to settle into a displacement.

First, as to the non-child-bearing wife. Inform her fully and seriously as to the gravity of self-induced abortions; the penalty from the physical side will frequently frighten her when the moral side has no effect. Teach the woman who is studiously avoiding pregnancy by the use of medicated wafers, and incomplete sexual congress, what probable physical fate awaits her. Much can be done to avert sub-involution following parturition if the obstetrical attendant is rigidly careful with his patient. With the wealthy class of people there is too generally an aversion, not infrequently backed by disability, to nurse the babe; this failure always has its effect upon the contracting uterus; and what would undoubtedly be a well-contracted and perfectly involuted uterus under the stimulation of a nursing babe, becomes a flabby, indifferent and sub-in-

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voluted uterus. Now add to that a tight abdominal binder, and the enforcement of a dorsal decubitus for three weeks, and the chances are very favorable for a retro-displacement. I am of the opinion that the parturient woman should not remain prone upon her back for more than two or three days following her delivery, and that after such time, she should change frequently from side to side. With patients who have previously shown a tendency to sub-involution, a slight displacement or a little prolapse, the greatest care should be exercised at the parturient period to prevent a more pronounced degree of the same difficulty; indeed, then is the best time to induce a cure of what has already taken place, and a good long rest in bed, with frequent changes of position, is one of the best factors in such a cure. Three or four weeks is none too long to remain off the feet. In no case should the obstetrical surgeon allow his patient to get up and begin her duties until he has satisfied himself of the exact condition of the uterus, its position, length and sensitiveness, and unless normal in those essentials, she must undergo further rest or treatment. I fear there is too frequently an indifference on the part of the obstetrician to these particulars, but the truth of the matter is forced very strongly upon the gynecologist, some years later, when he is called to treat such cases and learns by inquiry when the trouble first appeared.

Metritis following confinement will invariably leave a uterus enlarged. Those severe and well-nigh fatal cases of septic metritis produce such changes in the uterus that it requires careful attention to bring it down to anything like normal size. But if proper treatment be not instituted and persistently executed, the chances are greatly in favor of a life-long malady. It is here that a careful but thorough curettage is absolutely essential. No uterus can ever hope to attain a normal size so long as it holds a hypertrophied mucous membrane filled with plastic exudates. Long rest in bed, glycerine tampons, occasional but not too frequent douches, are great aids in accomplishing a cure.

I am of the belief that when an enlarged uterus is found, due to any cause, whether it shows a tendency to displacement or not, it is wise to institute treatment for its reduction; for by so doing we are taking strong preventive measures against displacements. Such treatment consists of curettage, glycerine tampons, regular bowel movements, daily exercise and light gymnastics. I need not add the remainder, which every gynecologist fully recognizes, that a lacerated cervix should be repaired, and every ruptured or relaxed perineum should be reunited. Indeed, all or any treatment to the uterus will be of little avail if these latter defects are allowed to remain uncorrected.

So much for the prevention of displacements. Now for the treatment after such has become established.

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Ante-flexions are to be considered entirely distinct from the retro-displacements, because they are undoubtedly due, in the majority of instances, to an undeveloped state of the uterus, and are, in consequence, a congenital defect. Here the treatment is largely hygienic. I have found in adult women that a cup-pessary gives much relief in this condition. There is a curious fact relative to ante-flexions in married women, and that is the tendency for such women to be sterile. I recall two cases of that nature wherein the patients had been married some ten years without children, and the wearing of a cup-pessary for a few months so overcame the difficulty as to enable them to become pregnant.

Treatment of Retro-Displacements.—In the milder form of cases, free from adhesions, tamponade, the knee-chest position, electricity and uterine massage may effect a cure. In these cases the pessary can be used to great advantage if managed rightly, which means not to allow the patient to wear it too long. In exaggerated cases, especially where adhesions have formed resulting from an old-time salpingitis or pelvic peritonitis, there is, to my mind, but one method of cure, and that is, ventral suspension or fixation, according to circumstances; of this I shall speak later.

The Alexander operation has not, in my opinion, fulfilled its expectations. There are so many conditions upon which it is dependent for success. *First,* the round ligaments, when found, must be strong enough to sustain the traction made upon them, and then they must not give out again as they did originally when they allowed the uterus to become displaced. *Second,* they must not give way after they are attached in their new position. This operation is applicable only in the less severe type of cases, and fails entirely when adhesions are present; neither does it allow the opportunity to examine the uterine adnexa, as does the ventral method.

In prolapse of the uterus we have an efficient and safe method of cure, which transforms a miserable sufferer into a happy woman. Certainly it is a pitiable state for a woman fifty or sixty years of age to go about with her uterus hanging outside her body. This condition is due to a combination of causes; a ruptured or relaxed perineum, a large uterus, a long conical os, over-stretched ligaments and vagina, due to frequent pregnancies; intra-abdominal pressure, resulting from abdominal obesity, intestinal indigestion and straining at stool. One of the early indications of approaching prolapse is the appearance of a rectocele or cystocele. In the absence of a strong perineal backing, the rectum has lost its support, hence the effort at stool tends to push the posterior vaginal wall downward and forward and a rectocele is established. With this stretching of the vaginal wall the uterus is pulled down and soon the anterior vaginal wall descends, bringing the bladder with it, and

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thus, a cystocele is established. Hence, in treating a prolapse the first thing to correct is the perineum; with that unrepaired, all other measures fail. Next look to the cervix. If that be long and conical, amputate well up to the vaginal vault. Especially is it wise to do this in women passed the menopause. Next, correct the rectocele or cystocele by an anterior or posterior colporrhaphy. But the most essential of all is the suspension or fixation of the uterus to the abdominal wall. This operation is so simple, so quickly performed, so devoid of all danger and so extremely satisfactory withal, that to my mind it has become the ideal method of treating all cases of exaggerated retro-displacements, partial prolapse or complete procidentia.

I shall not go into the details of this operation further than a few points which are essential to its success. *First*, the abdominal incision should be as low as the bladder will allow, and should not be over two inches in length. *Second*, the uterus should be brought so well forward that it becomes slightly ante-flexed, and thus the fundus, or even the posterior surface rather than the anterior surface, should be sewed to the abdominal opening. *Third*, the sutures (silk-worm) should pass through the uterine muscular substance and through the abdominal wall together with a number of catgut sutures introduced through the abdominal and uterine peritoneum. The operation is almost entirely devoid of risk and followed by very gratifying results; at least such has been my experience with it. The objection raised to it on the score of interference with future pregnancies is of no weight. The union between uterus and abdominal wall is peritoneal only in the ventral suspension operation, and when called upon to "give," as in developing pregnancy, this union simply stretches out into an artificial round ligament which does not seem to lose its grasp after the termination of labor. In older women the fixation method is better because it will hold the uterus for all time, even though the patient had a procidentia and is obliged to do heavy manual labor.

Another procedure is that of vaginal hysterectomy. This may be satisfactory in some few cases, but I doubt its practicability and its necessity. My experience has taught me that the rectum and bladder will prolapse just as badly after the uterus is out as before. Hence, we do not employ it.

I have been able to examine by abdominal section, two of my patients upon whom I had previously made the ventral suspension operation, after each had been confined, and found the uterus in a good position, with the adhesions still intact. Another young woman upon whom I made the operation one year ago has just been confined two weeks ago. She went through her gestative period with perfect normal conduct and her confinement was unusually easy for a primipara. An examination

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made yesterday showed the uterus to be in a normal position, whereas previous to the operation the retro-displacement had been so great that the fundus was wedged well down against the rectum.

In summing up I desire to make clear, *first,* the point that many of the exaggerated cases of uterine prolapse and retro-displacement are preventable by careful attention to the parturient woman and by a healthful manner of living on the part of the wife who seeks to avoid bearing children. *Second,* a partial prolapse or an initial displacement may be effectually checked by rendering the uterus normal in size and repairing all lacerations and ruptures. *Third,* the worst possible cases can be effectually cured by means of the ventral suspension operation.

DISCUSSION:

DR. T. H. CARMICHAEL: Mr. President, Dr. Wilcox thoroughly discussed his paper and I do not know that I can add anything to it except to corroborate what he has said. While some things he omitted to say might be mentioned, I shall, in discussing the paper, add to it some little explanations of some things he did say, that we may understand it somewhat better. He spoke of lying upon the back after confinement. I do not think that the general practitioner of today—not many of them—confine their patients to their back for any great length of time. We are in the habit, in our section, of allowing our patients to get up to urinate; to get up and use the chamber in bed, not using the bed-pan; after laparotomies, we turn our patients upon the side very soon after the operation—within twenty-four hours. So, after confinement, I cannot see the necessity of patients lying upon the back any great length of time. He speaks of the condition of sub-involution. This is a condition that is very liable to arise after laceration of the cervix in confinement, and of course the repair of that cervix at a future time will have a tendency to cause involution to take place. I do not think that any of our practitioners repair the cervix immediately after the laceration, unless they have a continued hemorrhage. In continued hemorrhages after confinement if you find there is a severe oozing, you will find the tear to have extended to the circular artery, producing the hemorrhage. Under these circumstances it should be closed immediately.

After uterine fixation—the Doctor called it uterine suspension—I think the technique that he employed was correct, except the use of the silk-worm gut. In my practice I do not employ silk-worm gut for this particular operation. I consider the chromatized gut better. This gut will last forty days in the tissues; which is sufficient to cause all the adhesions that are necessary. Now, in doing the operation, perhaps I employ a little different technique from what the Doctor does. I bring the uterus well forward in an anteverted condition, I put my sutures down through the muscle and peritoneum (the back of my fist representing a uterus) back of the cornu, up through the muscle again and tie it in that position; then I put the other on the opposite side. I do not put in any cat-gut ligatures after that, excepting such as are necessary to bring the abdominal wound together. This makes two well-defined posterior ligatures that will support that womb, and there is not as much danger from the loops of the small intestine getting in or through those ligatures and becoming incarcerated.

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WHY PRIMARY PERINEORRHAPHY IS OFTEN A FAILURE

SIDNEY F. WILCOX, M. D.
NEW YORK

We have all heard of the old doctor who has had such a wonderful obstetrical experience, including many hundreds of cases, and who has never had one in which the perineum has been lacerated. Of course it would not do to tell this wonderful man that he does not recognize a lacerated perineum when he sees it, or to intimate that he has been so unpardonably careless as to make no examination of a case after labor.

Fortunately, the modern doctor cannot often be accused of such incompetence or carelessness. He has been more carefully taught, and, as a rule, he recognizes the lesion and takes measures for its repair. I doubt if any up-to-date physician questions for a moment the propriety of primary perineorrhaphy in all cases where it is practicable, and almost every man will see to it that the lacerated perineum is sewed up at once. The advisability of asceptic or antiseptic treatment is taken for granted, so that we have two essentials for suceess in primary perineorrhaphy already admitted as being proper, and usually carried out. When one looks at a recently lacerated perineum, he sees a wound varying from a mere notch to a deep cleft, which may go down to, or even quite through, the sphincter ani, and the usual method of repair is to apply the raw surfaces one against the other, and to hold them in position with external sutures. When these are first placed in position the perineum appears to be perfectly restored, and remains so, apparently, so long as the sutures retain their original grasp on the tissues, and if the sutures are deeply placed in a rupture which is a clean split backwards, a very good result may be obtained. But there are many cases which do not constitute a clean split backwards or outward, and in which, although the newly-placed sutures seem to hold, later on there is a stretching of the tissues, and the result will be a thin perineal body which gapes easily, and which affords very little support. In such cases the laceration is only slightly apparent, externally; it is mostly inside the vulva, and may extend up to the sulci on either one or both sides, or it may be that, instead of running antero-posteriorly in its direction, it runs crosswise, so that, as Dr. Emmet has graphically described it, it is like the flap of a boy's trousers, which he has neglected to button up, and consequently it hangs down. In other words, a cross-tear has taken place inside of the vagina so that the external parts are torn loose from the pelvic fascia, and simply sag down, the sagging increasing as time goes on. As this sort of tear occurs mostly inside the vagina, and only

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shows slightly externally, if one is not careful only the slight external tear is repaired, while the internal, and more serious wound, is left ununited. The indications are simple. First, inspect all cases after labor carefully, both externally and internally, and note the extent and direction of the injury; then insert the sutures in accordance with the direction of the wound, so that an approximation of the flaps brings them into their original positions, and hold them there; and, last, and one of the most important points of all, use a large, full-curved needle so that the sutures can catch the pelvic fascia and hold up the parts which otherwise would prolapse and afterwards stretch.

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SECTION IN OBSTETRICS

Jos. P. Cobb, M. D.
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Practical Methods for Securing Asepsis in Private Obstetrical Practice.....Florence N. Ward, M. D.

Discussion: *A. R. Griffith, M. D.; Wm. A. Humphrey, M. D.; G. Forrest Martin, M. D.; Jno. Prentice Rand, M. D.; Benj. H. Ogden, M. D.; J. C. Fahnestock, M. D.; Lewis K. Maxwell, M. D.; H. W. Pierson, M. D.*

The Unusual Demands for the Use of the Forceps — Early or Late Use; High Forceps Application *versus* Version, *etc*....
George R. Southwick, M. D.

Discussion: *Benj. H. Ogden, M. D.; T. Griswold Comstock, M. D.; A. B. Spinney, M. D.; C. B. Kinyon, M. D.; Charles N. Dunn, M. D.*

A Successful Case of Artificial Impregnation..Emily L. Hill, M. D.

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PRACTICAL METHODS OF OBTAINING ASEPSIS IN PRIVATE OBSTETRICAL PRACTICE

FLORENCE N. WARD, M. D.
SAN FRANCISCO

The weak place in our obstetric art to-day lies in the imperfections in asepsis that prevail in private practice. The results are manifest in the high mortality and morbidity rates. It is difficult to obtain statistics for the mortality-rate resulting from puerperal lesions in private practice, but all authors are agreed that they greatly exceed the statistics in obstetrical hospital service, and the gynecologist can attest to the many lesions resulting from the minor grades of puerperal infection.

There is every reason for gratification over the advancement in our branch, and the brilliant achievements that have taken place in the last decade. For brilliant and daring surgical feats, we claim some of the greatest in the whole field of surgery, and for careful research and new discoveries we have held our own; but it is in the commonplace and every-day conduct of labor that our greatest imperfections lie. Upon this one line must we concentrate our efforts, and by the development of more perfect methods eliminate the avenues for puerperal infection.

The difficulties are many and ever-present that the obstetrician has to meet to secure asepsis in his private cases. All the more burdensome, by contrast, do they seem to the young practitioner, after he has been accustomed to the perfect conditions of a well-appointed hospital, where, with intelligent and well-disciplined assistants, every detail is so perfectly executed that the whole technique is without a flaw. In private practice, for each case he, himself, must inaugurate and carry out a technique that is apt at almost every turn to be rendered futile by the ignorant and untrained workers about him.

The anomaly exists to-day that a charity patient runs fewer risks of puerperal infection in a well-appointed hospital than the wealthy patient does in her own home. We have not reached that point in the education of the masses where all women are willing to enter a private sanatorium or hospital for obstetrical care, and, until that time does arrive, we must devise methods wherein we can obtain and maintain to the highest degree an aseptic technique that can be adjusted to all cases in private obstetrical practice.

To be a practical working thing, we must formulate a technique so simple that its execution can be carried out within reasonable limits of

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the physician's time and power, and yet so perfect that all avenues of infection must be avoided.

In considering the problem there are only three points to be regarded.

I. The field of operation; that is, the external genitals of the patient.

II. The hands of the operator.

III. Everything that is brought in contact with the genital canal.

In these lines the degree of asepsis must be perfect, or exactly the same as that which we aim for in abdominal section.

I. The asepsis of the field of operation, or the external genitals, is attained by the thorough scrubbing of the external genitals and neighboring parts by a hand-brush and green soap and hot sterile water, care being exercised that no trauma nor abrasion is produced by undue force. This mechanical cleansing is followed by a chloride cleansing, after which the parts are protected by a sterile gauze pad.

II. The second point, the cleansing of the obstetrician's hands, is the greatest problem, as we know how exceedingly difficult it is to get the hands so cleansed that cultures taken from them remain negative. This is particularly so in a long case of labor where, as the result of the natural exhalations, the hands soon show contamination. I prefer, after the scrubbing with green soap and water, followed by the lime-and-soda solution, the wearing of rubber gloves, particularly if the obstetrician has been in attendance upon unclean or pus-cases. There is a sense of absolute security in having the hands encased in rubber gloves that have come directly from the sterilizer.

III. The third point is that nothing come in contact with the genital canal of the patient but that which has been *baked, boiled or steamed.* Instruments, sponges, gauzes, pads, all must have passed through the process of heat to such a degree as to destroy all pathogenic bacteria. Even the most ignorant nurse will understand an order of this kind, and will be able to carry it out. The use of antiseptic solutions is many times a make-shift, upon which no reliance should be placed. Bichloride covers a multitude of sins and leads to lax and uncertain methods, besides giving a false sense of security.

A great aid to the bettering of asepsis will be a better preparedness on the part of the obstetrician; that is, that his armamentarium be more perfect. The obstetrical satchel of to-day does not belong to this aseptic period. It cannot be sterilized, nor is it adapted to the new wants of aseptic surgery.

Professor Edgar has contributed a new obstetrical bag, on aseptic lines, which is admirable in its completeness, but whose bulkiness and weight (it weighs twenty-five pounds) and expense will preclude its

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every-day use by the general practitioner, who is the one above all others needing an aseptic outfit.

The day is not far distant when it will be obligatory for the physician to be equipped with an obstetrical aseptic outfit before he is permitted to conduct a case of labor.

The ideal obstetrical case is one that, with its contents, can be sterilized and then closed ready for the emergency call. It should be so arranged that the sterilization could be accomplished either by heat or formaldehyde. With the thought of further advancing this line I have devised a new obstetrical case.

It is a nickel-plated metal box, 17x5½x5½ inches; long enough to hold the obstetrical forceps and large enough to contain everything, including dressings, for a case of labor. It is made on the principle of a gauze or conveyance box, with a close-fitting outer case, containing openings on all four sides, which fit corresponding openings in the box when it is raised, thereby allowing the steam to pass into the box from all sides, sterilizing the contents. When the sterilization is complete the outer case is slipped down, closing the openings and preserving the contents intact. The box has a cover which closes and fastens down upon one side. A handle for carrying the case is placed in the middle of the top of the cover. A black leather top-case is made to protect and cover the metal box, and is fastened by two straps passing around it. A stout handle is on the top of the case. This leather case is removed from the box before it is taken into the obstetrical room.

On lifting the metal cover, first is seen the wire-gauze tray, containing the obstetrical instruments. This tray is divided lengthwise into two compartments. One compartment contains one pair long obstetrical forceps and one pair short obstetrical forceps; one pair long uterine dressing-forceps for packing of the uterine cavity in case of hemorrhage; one pair of long bullet-forceps to grasp the cervix in case the uterus must be packed. In the smaller compartment are needle-holder; six artery forceps; blunt-pointed scissors for cutting the cord; long, sharp-pointed scissors; Doyen perineal needle; saline infusion; needle; scalpel, and ordinary needles—in short, all the instruments needed for repair of lacerations or minor surgical work.

On lifting out the tray we remove all the instruments of the case together. The advantage of this is that the tray of instruments can be placed in a vessel of water and boiled separately, if it is so desired, or if they have accidentally become contaminated. At one end of the case, in a light frame, are eight two-ounce bottles, containing chloroform, ergot, brandy, bichloride tablets, lime, soda, vaseline and liquid green soap. These have glass stoppers, and are plainly marked, and are the only articles that do not remain in the case while it is being sterilized.

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They are placed in the case after it is removed from the sterilizer, being carefully wiped off with a strong solution of bichloride before being put in their places. The lower part of the case contains a sterile gown for the physician, and the following articles, each contained in a linen bag, 8x4 inches, and each plainly marked in indelible ink:

1 douche-bag and glass nozzle.

2 scrubbing brushes.

2 pairs rubber gloves.

5 yards gauze, 2 inches wide, for packing the uterus in case of hemorrhage.

1 dozen vulva-pads, each 1 yard square, that can be unfolded and placed around the field of operation in case of surgical work.

2 dozen gauze sponges for sponging the vulva or in suturing a laceration.

2 dozen cotton sponges for cleansing the child's eyes, nose and mouth.

Besides which, in smaller bags (2x4 in.) are silk-worm gut ligatures and silk ligatures for suturing; silk ligatures for tying the umbilical cord and a catheter.

In short, everything needful for the conduct of a case of labor under ordinary conditions, and everything fresh from the sterilizer without the possibility of contamination by being handled or removed from one receptacle to another. The case fits the Kny-Sheerer small office sterilizer, or it can be placed in an oven and sterilization accomplished by dry heat, or in an ordinary wash boiler to be steamed, providing it is placed upon blocks to lift it above water-level.

When the obstetrician arrives at a case of labor with this case, all he has to have prepared for him are plenty of hot and cold sterile water, and some dishes and basins boiled to contain his solutions. While he is using the sterile dressings he has brought with him, he can have fresh cloths baked in the oven to answer for vulvar dressings during and after the labor. Though the case is compact, there is still room for instruments or other things that different physicians might personally desire. A pelvimeter might easily be laid beneath the tray, scales could be added, and a tape for measuring.

The case complete and filled and including the leather cover weighs only twelve pounds.

With a sterile outfit such as this, and with the physician guarding his hands and field of operation from contamination, each link in the chain of asepsis should be complete, be the scene of his labors in the squalor of the hovel or the home of wealth.

The conduct of the puerperal period can be carried out on the same lines as those observed during labor, namely to avoid contact with the vulva as much as possible, no douches, spraying the parts with sterile

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water only, and protecting them with sterile pads, baked or steamed gauze. Under these precautions every case should pursue an aseptic course.

The advantages claimed for the case are, *first,* its compactness and completeness; *second,* the easy and perfect sterilization of the case and its contents; *third,* its light weight.

It can be procured of the Kny-Sheerer Co., New York.

DISCUSSION:

A. R. GRIFFITH, M. D.: The excellent paper presented by Dr. Ward is worthy of the most careful consideration. The subject is of the utmost importance to the general practitioner. Every family physician should be an obstetrical specialist. A great responsibility rests upon him when he is called upon to practice the art of midwifery, and especially if without the aid of a trained nurse. And, unfortunately, trained nurses are rare in the country, as well as amongst the poorer classes of the great cities. It is my desire to emphasize all the good points introduced by the writer and to add whatever my experience may suggest, where I have had to work alone or with only some inexperienced neighbor as an assistant. Every practitioner so situated will endorse the opinion of Dr. Ward, who has aptly said that all the efforts of the physician are likely to be negatived by the ignorant and untrained workers about him, no matter how perfect may be his technique. How to successfully overcome this difficulty has doubtless troubled many a conscientious mind. Unfortunately, many women are so accustomed to filthy surroundings that were they properly bathed and cleansed they might lose their immunity from infection and speedily become a prey to the deadly germ—at least that has sometimes appeared to be a clinical fact. And yet, when these women are about to become mothers it is our duty to adopt all scientific precautions for their safety. In the average home of the poorer classes it is almost impossible to secure an ideally aseptic confinement, and in many homes it is absolutely impossible. The bed and bedding, the walls and floors of the room, the very patients themselves are generally laden with germs sufficient to cripple and destroy life if once they gain entrance to the human body. How to successfully fight this battle with an unseen foe requires the earnest attention of every physician. Personal cleanliness, with the utmost care, must be the first requisite. And yet may I plead an excuse—but not a justification—for the busy practitioner who does not keep his obstetrical bag always in an aseptic condition. He has no office nurse, and no help except his own two hands. Oft-times tired, depressed, and discouraged from long drives and loss of sleep, is it any wonder that he allows himself to become careless or indifferent! And perhaps his long years of success have made him over-confident. It is the old story of familiarity breeding contempt. Well do I remember one of our late lamented Dean Helmuth's Sunday lectures when he emphasized this point and impressed upon his boys the necessity for eternal and ceaseless vigilance in the practice of medicine, and especially in surgery and obstetrics.

In my early practice I had nearly one hundred cases of midwifery

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that were absolutely normal and without a suspicion of danger. Then came the awakening—a flood of difficult cases, with two deaths from septicemia. And never shall I forget the first one—a severe rigor in the afternoon, immediately after my visit; the old-woman nurse sending no word for over twenty-four hours, and quieting the patient by saying the chill did not amount to anything—a temperature of 106 F. when I reached the case, and a very rapidly fatal termination. Such lessons as these teach us that at least we should be ever on the alert, for I must confess that in those early cases I allowed myself to be influenced by the patient and the nurse, who also happened to be the washerwoman and general-utility man. Old sheets were used, and a proper degree of asepsis was not enforced. But I have found it adds to my peace of mind to insist upon certain terms being carried out, even at the risk of losing the good-will or patronage of the patient.

The technique suggested by Dr. Ward regarding the cleansing of the external genitals of the patient is all that could be desired—for hospital or sanitarium. But I fancy the general practitioner will recognize the difficulty of following such a course in private practice. And the most stubborn difficulty will be found in the objection of the patient herself. You dare not trust your untrained assistant, whose finger-nails are generally in mourning and a fine breeding-ground for the germs you are seeking to avoid. Ask her for hot water and she will pour it into a basin for you and deliberately put those septic fingers therein to test the temperature of the water. Nine times out of ten, if you pour out the water and ask for more, you will require to wait for it to boil, while all the time your patient is pleading with you to hurry up. Unless you have given definite instructions beforehand, you will have no cool boiled water, and will be forced to wash your hands in very hot water. The old nurse will cool it with water from the tap or the bucket unless you watch her very carefully. Delicate women object to much exposure of the genitalia, especially during the early stages of labor. And so, where a competent trained nurse is not present, it has been my practice to cleanse the parts as well as possible with sterile water for the preliminary examination. With the exercise of a little care there need be no danger of infection at this time. I never use a hand-brush; it is almost sure to produce some trauma upon the tender parts, besides being disagreeable to the patient. As the pains increase, a further cleansing of the parts can easily be effected. Much of the hair can also then be removed with scissors. During the progress of severe pains the patient has never objected to this. If there is a remote possibility of any laceration the parts are then more thoroughly cleansed by the use of green or ethereal soap. I have used many different antiseptic solutions—have poisoned more than one susceptible patient with bichloride—and am now inclined to believe that pure sterile water is all that is necessary for ordinary cases.

The cleansing of the hands and arms I must agree to be a problem of much concern. They should be scrubbed most faithfully, and in this case it matters not whether a trained or untrained nurse be present—the physician must do the work himself. After thorough scrubbing it is always advisable to soak the hands in some antiseptic, permanganate, bichloride, creolin, formaline, etc. Especially should this be necessary if the physician has been attending a contagious or pus case. In long,

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tedious cases it has always been my practice to protect my examining hand with a sterile towel between examinations, and to have a basin of sterile antiseptic solution at the bedside. Latterly I have adopted the rubber gloves; they are an ideal protection to both physician and patient, and should become a necessity with every general practitioner. They are more easily boiled than one's hands, and can always be quickly sterilized. If forced to leave the case the gloves should be left in sterile water. The use of gloves, however, should never tempt the physician to carelessness in cleansing his hands, for at times it may become necessary to remove them during the progress of labor, especially if the placenta should be adherent.

The third point, that everything brought in contact with the genital canal must be sterilized, is absolutely correct. But let me warn you how very difficult this becomes without the help of a trained nurse. The ignorant neighbor or the cheap nurse may understand the directions all right, but will she carry them out? Half the time she will consider any special care all nonsense, and continue to work in her usual slovenly manner. The physician must personally superintend the boiling of instruments, *etc.*, if he would have it properly done. It is usually my practice to have needles, instruments and sutures boiled and ready for any possible laceration in all primipara.

The aseptic obstetrical satchel presented by Dr. Ward is a model of completeness. It would be an acquisition to any physician's outfit, and I would advise its adoption by all young physicians. But, unfortunately, many of the older practitioners have become accustomed to the old-fashioned leather case. And to this the physician must give proper attention if his technique is to be complete. A careless man would be equally as reckless with such a model case as referred to by Dr. Ward as with any other. The obstetrician has no business to be careless or unclean. He has no right to be tired or depressed. He must ever be on the alert. He must be almost more than human in his powers of endurance. His instruments must be kept clean and ever in readiness. They can always be kept in a sterile cotton bag or enclosed in a sterile towel. All the articles mentioned by Dr. Ward can be kept in this way in the regulation leather bag.

It is often an excellent experience to be forced to work without the help of a trained nurse, for then one depends more upon his own resources. But it does not always do to act upon one's own inspirations. A case in point recently came under my notice where a well-known physician found it necessary to rupture the membranes during the progress of labor. The most convenient instrument happened to be a hair-pin, and removing this from her hair—without any attempt at sterilizing—she punctured the membranes. I am bound to say no bad results followed, but that was not the fault of the physician. Doubtless there have been just as glaring instances of violation of obstetrical technique by physicians of the sterner sex.

Where only a neighbor or untrained nurse is caring for the patient one of the most important parts of the aseptic technique comes after the physician has left the house. The best way to enforce the directions regarding the care of the external genitalia is to tell your assistant in the presence of the patient just what you expect her to do. As a rule, the

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patient will see that the orders are properly carried out. Otherwise your nurse will often violate all the rules you may give her.

If success we expect to gain, the most rigid attention must be given to the smallest details of all obstetrical work. Always remember the influence of heat. Poor indeed must be the house where you cannot secure fire and water—and with these the careful physician may attain a fair degree of asepsis and remove the dangers that so often lurk about the accouchement bed and jeopardize the health and life of your patient.

WM. A. HUMPHREY, M. D.: The essayist has given us a feast of good things in her most excellent paper, and has completed her work so well that we are left with very little opportunity to create discussion upon this important subject.

It is from the standpoint of the physician who has at his disposal the trained nurse that we are expected to discuss briefly this paper. The day for the universal patronage of the lying-in hospital seems so far beyond our grasp that only the stretch of imagination brings it before us at all; hence, we must aim at things whose realization we may hope to attain for our present needs. In this we are assured by experience that the trained nurse will supply the want which formerly was so keenly felt by the obstetrician. The nurse, an outgrowth of necessity and the logical product of it, is filling the place designed for her and is the means by which much of the success attained in practical application of asepsis to obstetrical practice has been obtained.

Where we have the service of the trained nurse there is no reason why we cannot have the same success in the home as in the hospital, the only difference being that the details of preparation are new in every case, and may require a little more trouble, but the results can be obtained and should be sought with the same vigor they are in the hospital.

No duty that the obstetrician has to perform is so eagerly sought or better received than the giving advice to the expectant mother. She is always willing to assist in every way she can, and will do so if the physician will only suggest what to do and how to do it. It is but one step further, after telling her how to prepare the bed, to instruct her how to steam and bake towels, napkins, etc., and to show her how to put them in packages and keep them there untouched until they are needed. If emergency arise, they are ready and can be used. If the nurse be on time she can re-sterilize, if necessary, and if the supply be small she can commence at once and prepare all that is necessary. The preparation of the patient should be left entirely with the nurse, under direction of the physician. This is her duty; in fact, her profession, and when she fails in this her calling is gone.

In the preparation of the patient we should emphasize the necessity of the rectal enema and vaginal douche; also, if there be a history of vaginal discharge.

We cannot endorse the universal application of the scrubbing-brush to the parts in private practice. Patients will not permit it, besides, gentler means persistently used will bring the same results. After cleansing the parts thoroughly with soap and water, by means of gauze sponges, application of alcohol or bichloride will render the field surgically clean.

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The essayist has ably described the preparation of the physician's hands, and has emphasized the advantage of rubber gloves, which are worthy of all praise given them; they do add a sense of security furnished from no other source, and ought to be worn whenever possible for the better protection of both physician and patient. When physicians object to the use of gloves much security is added by frequently immersing the hand in an antiseptic solution and keeping it wrapped in a sterile towel. For this I prefer a potassium-permanganate solution, leaving it on until after labor is completed, when it can be removed by a solution of oxalic acid.

We would urge the necessity of infrequent vaginal examinations, making them only when required and using only a sterile lubricant, or none whatever. After the completion of tedious or difficult labor, where the parts are bruised, abraded or lacerated, we believe thoroughly in the use of douches, repeating them every six, twelve or twenty-four hours, as occasion may require. Even in normal cases, we have a surgical condition, plus drainage, which is more certainly controlled with antiseptic douching then without it. I have never seen bad results follow their use, while the reverse is true with their employment. Personal experience has compelled me to become an advocate of the use of the douche in the large majority of obstetrical cases. To this I hear the objection that the preparation of the hands is incomplete; to which I respond, if that be so then antiseptics go for naught, and the practice of many of my co-laborers is worse than criminal. Difficult as it is to keep the hands sterile, I am unwilling to place all blame upon the physician for all the cases of infection which appear in obstetric practice. Even the closest scrutiny will fail oftentimes to discover an old suppurative catarrh of the middle ear or the nose, or the germs of pus hidden away snugly within a Fallopian tube, or the briny discharge of a rectal ulcer; the discharge of any of which, when absorbed by the genital tract during the lying-in, will produce trouble. With all the precautions for the aseptic field and the hands of the operator, we should not fail to extend our investigations to the whole anatomy of the patient and nurse as well. We shall thus be able to account for the causes of many cases which otherwise would have remained in hopeless obscurity, and whose presence is the signal for censure upon the attending physician.

We congratulate the essayist upon the obstetrical case which she has contrived. It is complete, compact, and is a great stride forward for the better application of asepsis in the obstetric art.

It may be added that sterilization is the only perfect method, no matter how complete the case. Sterilization of instruments and dressings is a simple matter, compared with that of the physician's hands, which are the great culture-field for germs. This is paramount to all other preparation. The obstetric bag is of secondary importance.

G. Forrest Martin, M. D.: Mr. Chairman, I want to express my pleasure at listening to all these papers. The two sides of the question have been admirably presented, and Dr. Griffith has illustrated, I think very forcibly, some of the common conditions which we are most apt to meet. There are many points in Dr. Ward's paper that would bear

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full discussion, and I want to take the time of this Institute just long enough to refer to one, and that is to sound a note of warning about the rubber gloves. The last speaker has spoken of the sense of security which the rubber gloves give to the obstetrician. I agree with him, but I am positive that they often give a *false* sense of security. Now don't misunderstand me. Rubber gloves will not take the place of eternal vigilance in obstetrical work. I have repeatedly seen, in general work, men come into the operating room, wash their hands and arms with soap and water; take one half-cleaned hand and work on a rubber glove, contaminating that glove; and then take that contaminated glove and work the other glove on with it. Now, some one has tritely remarked that "soap and water answer the demands of society, but not of surgical practice;" and a cleansing of the hands before inserting them into rubber gloves, with simply soap and water, will not add anything to the security from the use of the gloves. A man who is going to wear rubber gloves in his obstetrical practice should, before putting them on, carefully not only wash, but sterilize his hands, or else take some other precaution before rubbing them on. That, if you are in a hurry, can be met by having boiled with the gloves a towel or cloth which can then be used in rubbing the first glove onto the hand. But I want to just sound that note of warning about what I believe is often an overlooked point in the use of the rubber glove.

And after the gloves are on, I want to sound another little note of warning. We will suppose that the operator has made himself absolutely sterile. He has, to start with, made the patient sterile so far as can be. He cannot make the contents of the rectum sterile, and it is almost impossible to go through a case of labor without some contamination from the anus occurring; and if you have rubber gloves and think that they are sterile because you are wearing sterilized gloves, you are mistaken. You will have to wash your hands, or wash the gloves rather, just as often, and as faithfully, as you would wash your hands.

Now, one other point: Certainly the old obstetrical bag is not aseptic. The present bag on exhibition is a great improvement on it, but I should hesitate to regard the contents even of that as sterile, on reaching the lying-in chamber, if they have been going around in a buggy, or been lying for some little time unused. It seems to me the only safe practice is, when you arrive at the lying-in chamber, to regard everything which you are going to use as contaminated—I mean, in the way of instruments—and boil them then and there. If you view them in that light, you can take them out of your old obstetric bag, wrapped in gauze of course, and sterilize them anew at the time. I think that is the safe way with any obstetrical bag.

I should like to get the opinion of the distinguished author of this paper in regard to one point, namely, the clipping of the vulva. I may possibly have escaped any mention she made to it. I would like to know whether she favors, in practice, the shaving of the external genital, or of clipping off the hair. And I want to say a word in regard to soap. I detest any soap in the cake form, which you have to put down on something and then use again. The only safe way is to use a liquid soap, which is contained in a bottle and which will use drop by drop as you need, the remaining soap being absolutely free from contamination; and

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there is (if it is proper to allude to a certain article) an antiseptic soap which is called Cina Soap, which I believe to be a very valuable adjunct to surgical and obstetrical practice.

I should be very glad, then, to hear expressions of opinion on these points still further, and particularly the one I have just alluded to—the clipping of the patient before making the examination or before attempting to sterilize her.

JNO. PRENTICE RAND, M. D.: There is just one suggestion that I would make to the author in regard to keeping the contents of that case sterile; and that is, after it is sterilized, put in one of those candles of formaldehyde and carry it as a part of your case. I wish to congratulate Dr. Ward very much upon the paper, and upon the case which she has exhibited here to-day.

BENJ. H. OGDEN, M. D.: I think we cannot too highly commend the idea which has been presented to us in the paper. I believe that there are many difficulties in carrying it out in private practice; but where there is a will there is a way, and if we will to do it, we can meet the difficulties. The one thing which we need is to instruct the public, and as physicians to believe in the necessity of the best aseptic technique in the treatment of obstetrical cases. You will be surprised to see how many among the public—and I am sorry to say, how many among physicians—ridicule and laugh at the suggestions which are made in such a paper as this. We want to keep constantly before us the fact that it is not true that in the lower walks of life there is less death than in the higher; that it is not true that there is less death among the people in private practice than in hospital practice. The reverse is true and can be abundantly proven if anyone will investigate. One of our chief duties, I think, at the present time is in the line of education to bring the public and to bring physicians up to the idea of doing the very best possible in practicing the ideal aseptic treatment of obstetrical cases. This includes not only all that the paper has suggested but careful attention given to the immediate and proper repair of all lacerations.

J. C. FAHNESTOCK, M. D.: This admirable paper has brought this subject to the point that all cases of obstetrics are purely surgical measures. They have forgotten that an obstetrical case should be a perfectly physiological process. If the case has been properly taken care of and the system properly put in shape, an obstetrical case should be a natural physiological process. Cleanliness is next to Godliness, and if those features are carried out, I think success will follow in all cases.

L. K. MAXWELL, M. D.: The preceding speaker said that it was wise to have the mother in an aseptic condition previous to conception. I find in my obstetrical practice that fully 90 per cent of cases of infection arise from a lack of asepsis previous to that. A year ago, in the hospital with which I am connected, there was a woman confined by one of the most aseptic men in our city. Every precaution had been taken; she had been in the hospital for at least ten days or two weeks previous to the confinement, and at the end of about three days

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following accouchement she was taken with a chill and there was a very high grade of inflammation in the pelvis, and her life was jeopardized. He was very much worried and annoyed, and censured himself for perhaps not having some link perfect in his aseptic chain, and called me in consultation. The same night that this woman was confined, only a few hours afterward, I was called to see a case, a woman who lived in a poor home and who could not have the proper care following confinement. I found her in such a condition that I barely had time to get her to the hospital, but I ordered a carriage and started for the hospital, telephoning ahead to have a bed ready for her. She was put immediately into the bed. It gave us no time to clean her up properly at all. One amusing thing occurred in connection with it: the bed had been prepared by a junior nurse, who had not yet been taught asepsis thoroughly; she had been in only a few weeks, and she used ordinary sheets which were not sterilized. One of the senior nurses came in just after the bed was completed and the patient had been put in, and said: "Did you put on sterilized sheets?" The junior nurse replied: "Sterilized sheets? No." "You ought to." "Pshaw! What's the use of sterilized sheets? Wasn't Christ born in a manger, and was there any record of infection at that time?"

This case that had so little care went on without trouble of any kind. The other was a very serious case, and the doctor censured himself for probably having a broken link in his aseptic chain. I told him I would advise having the husband in consultation, and after questioning him very closely we found that about three months previous to the conception taking place the husband had been infected with gonorrhea, and that condition was no doubt the result of gonorrheal infection. A great many practitioners would have been inclined to censure themselves. The laity would have censured them had that occurred in a private home in which the proper precautions had not been observed. I merely allude to this that we may not censure ourselves ofttimes when the results are so. I would advise a thorough aseptic condition of the husband previous to conception.

A. B. Spinney, M. D.: The paper is admirable and the discussions have been highly interesting, but I would like to ask the author of the paper in her closing what suggestions she would make if she were in charge of a lying-in hospital in relation to the care of the patient for three months previous to confinement; whether douches should be used or not; what kind of douches, and what kind of care the patient should have in addition to what has already been said.

H. W. Pierson, M. D.: The author of this paper has given us very definite instruction, covering every imaginable phase of asepsis in the mechanical management of an obstetrical case, but we feel that there is another phase of the question that is of equal, if not greater, importance to the obstetrician. The tendency is to magnify the importance of thorough asepsis, and ignore the means that might be employed for securing a constitutional vitality that would afford equal, if not greater, protection than that secured through external means. Every close observer has noted the peculiar susceptibility of some individuals to almost every kind of exposure, and know that they are the most liable to

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infection from every possible source. Others seem to have such perfect immunity that they may be exposed to the most unfavorable environment and come out without a blemish. To our mind it seems as though greater study should be given to the removal of internal causes when the real importance of asepsis would be given its legitimate place in medicine.

No time is so favorable for the development of constitutional susceptibilities as the period of gestation, and the obstetrician is certainly remiss in his duties if he ignores the great importance of this phase of the work.

FRANK L. NEWTON, M. D.: This is a very admirable paper, and very admirably expressed. It seems to me it is quite æsthetic, and criticism is hardly possible. It seems to cover every point up to the present method of suggestion in asepsis, as well as in antisepsis. I can scarcely see a possibility for criticism in this paper for the purpose for which it was written. To expect that any or every general practitioner can carry this out to the letter is almost impracticable, and lacks possibility, among the surroundings we have to meet in general practice. We have heard several conditions under which septic infection may be carried; one wants soap in a bottle; another does not want it in a cake; and so we might go on, *ad infinitum*. But we all, as obstetricians, have to come in contact with the various parts of clothing. Unless we have plenty of assistants and can go around in the operating room with our hands unhampered, some one to wait upon us, to turn the clothing, one here and another there, we cannot keep ourselves absolutely clean. That is an impossibility. We have got to come in contact with some of these things. But in this paper this is cut out so far as it can be. But to have everything ready, prepared, and boxed in a case of that kind seems to me to bring the chamber of the ordinary case of obstetrics into a condition as near that of the perfection of the operating room as we may expect to get. I do not think the author of this paper thinks but that there are possibilities away beyond what this may reach in the home, but this comes the nearest to it, and we have practically got everything we need and made everything clean; and the fact of carrying this case with us is all the time a suggestion that we must keep it clean. The very fact that you have brought the ideal lying-in operating room in your hand is a suggestion to you all the time, and it certainly would be a good teacher if every obstetrician would have something of this kind and carry it about in his bag and know that he had something with him that was just as clean as it could be. Now, if you do not feel absolutely secure, then when you come to the house you can still further satisfy yourself by sterilizing them. There are other obstetric arrangements similar to this, which have a sterilizer, with an alcohol lamp and all the paraphernalia for doing the work right then and there at the house. You can repeat the process there again, if you are not satisfied, or if you are conscience-smitten from having carried it about a long time, or it has been too long sterilized. But I think when the author has taken the pains to go over the work and show to us the perfectness of a case of this character, I think they have given us a good lesson; and I hope that all the obstetricians throughout the country who are represented here will procure something of the kind, if for nothing

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more than as a teacher, and something to practice with, and something to bring them up to the high ideal which the lying-in chamber and the surgical operating room of the hospitals of today present.

I wish again to thank Dr. Ward for bringing from California to the East here these suggestions, and bringing them out in such a way as she has, so that we will all talk about it, and think about it, and take these suggestions home with us and put them into practice.

FLORENCE N. WARD, M. D.: In working out the technique, I have tried to make it elastic enough to cover all classes of cases. For instance, in thinking of those cases to which our students go, in the poorest walks of life, in the tenement districts, conditions are far from cleanly. It is impossible to change the conditions of bed clothing, mattresses and surroundings, but the thought is to cleanse the *immediate* field of operation; that is, the external genitals. In those patients who live in crowded districts, it is impossible to cleanse with a surface cleansing of bichloride, and for that reason I advise the use of the scrubbing brush; but I lay special stress upon its gentle use, so as not to produce trauma. It can be done and is done continually in our work in this class of cases. Using the brush lightly, but getting up a good soap lather all over the external genitals. If proper precautions are exercised about this cleansing the patient can be kept aseptic. The next point: About clipping the hair. Our patients are usually very much adverse to shaving of the the parts, so that if the hair is abundant we simply clip freely. In the primapara there is always the liability of lacerations, so we clip the hair on the lower part of the vulva, thereby having a free field for the sewing up of the laceration. Then a point I did not touch upon is the practice always of sewing up every laceration, so as to leave no point for entrance of pathogenic bacteria. Sew it up immediately. (Applause.) Under these conditions there are no raw surfaces left. If there are abrasions on the vulva or around the vestibule, they take but a few moments to repair, and the great advantage is that there are no raw surfaces left, either in the vagina or perineum.

Then under these conditions I must raise my voice again against douches. In the first place, why should we give douches? The vagina is, under normal conditions, a clean canal; then why trust, in the hands of ignorant women, the application of douches to this sterile canal? Many of these patients have to depend upon a neighbor for help. The neighbor does not know how to prepare the douche bag, how to prepare the water, nor how to render the surroundings aseptic. She puts her fingers into the water to test it, the tube dangles against the wall, or comes in contact with any other foreign substance, so that by the time the water is introduced into the vagina it is pretty badly contaminated. Nature preserves a clean canal under normal conditions, and if there is a normal vagina, nature drains it and the case pursues a normal course. One physician has asked, what shall we do with the patient three months before labor, to prepare her aseptically for labor? We should do nothing to prepare the patient aseptically three months before labor. The aseptic preparation takes place immediately before and during the beginning of labor—in contradistinction to the physiological preparation which may be inaugurated any time during pregnancy—to meet the necessities of the particular case.

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THE UNUSUAL DEMAND FOR THE USE OF THE FORCEPS—EARLY OR LATE USE—HIGH FORCEPS APPLICATION VERSUS VERSION, ETC.

G. R. Southwick, M. D.
BOSTON

Munchmeyer's declaration that forceps was the most bloody of all obstetrical operations, as compared with the dictum of the Berlin clinic that forceps was the safest and most beneficent of all operations, has led to renewed study and reports of the use and results of forceps in nearly all of the large Continental clinics. These reports of carefully observed cases since the introduction of asepsis are of special importance as indicating the effect of the latter on the modern practice of obstetrics by the experts of Europe.

In a general way it may be said that the German School holds firmly to conservative lines, especially as regards the application of the forceps at the brim of the pelvis, and very generally declares against them if the head is movable above the brim. The Paris obstetricians, influenced by the axis-traction forceps, follow similar lines, but use the high forceps more freely. The English School resort to forceps earlier than either, and in America, where uterine inertia alone is accepted by many physicians as sufficient reason for interference, the forceps is used still more freely. This tendency to what one will call the abuse of a safe instrument, and another will term the humane use of the forceps, deserves serious consideration.

The results of experience are the final and most conclusive appeal to our judgment, and while it is not the writer's intention to quote details of statistics which can be found by those who are interested, a brief summary of the results obtained by the masters of the art is helpful in arriving at any conclusion.

The maternal mortality from the use of forceps does not include, usually, cases infected before operating, or those where previously-existing complications are likely to prove fatal, such as eclampsia-minor, pelvic contraction excepted.

The infant mortality, for the same reason, applies only to infants who die during delivery or a few hours afterwards. Maternal morbidity, as shown by the rise of temperature above 100 degrees F. in the puerperal state, with similar elimination of factors producing elevation of temperature independent of the mode of delivery, is more important in estimating results than in estimating mortality. A woman may finally

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recover in a crippled condition after a long illness, but those who recover without a rise of temperature above 100 degrees will show more accurately the character of the labor and delivery. The morbidity is not mentioned in all the reports, but as it is given in over fifteen thousand cases, it may be presumed to be fairly correct.

The statistics given here in a general way are founded on the reports of the maternities of Dresden, Prague, Vienna, Berlin, Halle, Bonn, Munich, Basel, Tubingen, Buda Pesth, and several other cities.

The teaching of antiseptics produced remarkable results as early as 1885. At this time a report of 50,752 births in Central Germany showed that the forceps were used once in 37.8 labors, with 1.4 per cent mortality for the mothers and 9.8 per cent for the children. The morbidity was not given.

The strict observance of modern asepsis in all maternities has improved in later reports. Twelve representative clinics show 30,737 births, with an average use of forceps in 3.54 per cent of the cases, or about once in thirty-three labors. The least frequent use of forceps was in the Dresden clinic, where it was used once in fifty cases, with no mortality of the mothers. The morbidity of the mothers was 23 per cent; *i. e.*, only one woman in four had a temperature exceeding 100 degrees F. during convalescence, and 12 per cent of the infants perished. It is only fair to state that in this clinic the forceps is not applied to the head above the brim, version being the operation of election. The Basel clinic showed the largest proportion of forceps of the German clinics, but it is in a section of the country containing a high percentage of contracted pelves. The forceps was used here once in twenty cases, or more than twice as frequently, with no mortality of the mothers, a morbidity rate of 24 per cent and a mortality for the infants of 10 per cent. The average of the cases reported approximated closely to a morbidity of 17 per cent, which means that five out of six women delivered by forceps have temperatures less than 100 degrees F. during childbed. It is freely conceded that the use of forceps should have no mortality in uncomplicated cases. The average infant mortality in these 30,737 cases was 10 per cent.

It should be remembered that the statistics quoted are from clinics where exhaustion of the mother and flagging pains, without other clinical evidence, is not accepted as an indication for forceps, and where it is a general rule not to apply forceps unless the head has remained stationary in the pelvis for two hours after it has failed to advance or recede. The American physician, true to his instincts and innate chivalry, takes a more humane position, and uses the forceps much more freely, while his English cousin occupies the middle ground, and believes firmly in high forceps.

That prince of all instruments, the hand trained by experience and

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thorough familiarity with the mechanism of labor, occupies a higher place with us than elsewhere, and it is very natural that manual dexterity should accompany Yankee ingenuity.

We gradually have recognized the fact that manual dexterity counts for much in rectifying abnormal positions and flexions of the head, which very often are the real source of difficulty in effecting a safe delivery. The hand of the expert sometimes fails, but it not infrequently simplifies a severe case of dystocia and aids materially in rescuing mother and child from a perilous position.

Abnormal positions of the head at the brim, or extension of the occiput, can be corrected manually in many cases so as to allow the immediate application of forceps bi-parietally to secure the head in a new and favorable position, rather than to force immediate delivery, which, on the contrary, should be performed slowly and carefully. This use of the hand in correcting brow, face, occipito-posterior positions, and extension of the occiput in vertex positions, deserves wider application in connection with the use of the forceps than has been given it. The success or failure of such manipulation is important in electing the use of forceps at the brim, or version, and if the effort is not successful the operator can proceed at once to either version or forceps without detriment to the mother. The secret of success in some cases lies in pushing the head back, rotating the body of the child by its shoulder with the aid of the external hand, then flexing the occiput with the fingers passed well over it and following this manipulation by applying the forceps at once to secure the flexion of the occiput anteriorly.

The election of high forceps version must depend somewhat on the dexterity of the operator with the one or the other operation, and especially upon the skill of the assistant which he can obtain. It has been well said that the skill of the assistant in version should be equal to that of the operator. In the German clinics, where such assistance is available to express the after-coming head during extraction, version is almost invariably preferred to the application of the forceps to the presenting head above the pelvic brim. It is not unusual in England to apply the forceps in such conditions if the cervix is soft and two-thirds dilated, with no disproportion between the head and the pelvis. Germany is very conservative in this operation, as her records show an infant mortality of 50 per cent from high forceps, and the danger to the mother exceeds that of an ordinary abdominal section. The report of the first one thousand cases delivered at the Johns Hopkins Hospital shows a better result, and is confirmatory of the English practice. If the conjugate at the brim measures 10 centimeters or over the forceps is applied tentatively, and if the head does not descend after two or three tractions version is performed. There was no mortality from either

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forceps or version in these cases. The infant mortality after forceps in deformed pelves was 9.52 per cent, and after version 26.66 per cent. The latter is much more than the statistics given by Wolff for aseptic cases, in which the maternity mortality is one-half of one per cent, and the infant mortality is 12.45 per cent.

The application of the forceps at the brim should be made as nearly as possible over the parietal bones, and requires no small degree of skill. It has been well said that high forceps is an operation for the expert, and version for the novice, when the two operations are considered.

It is hardly necessary to urge the value of some form of axis-traction forceps in preference to the long forceps. The position of the patient may not seem to be important. If Walcher's position is not used the writer much prefers to have the patient lie on her left side with the thighs well flexed and the hips over the bed. Axis-traction is thus performed more efficiently and the head is grasped more readily by the forceps.

Walcher's position, which consists in placing the patient in the dorsal position with the hips over the edge of the table and allowing the legs to hang down, is very important for either high forceps or the extraction of the head after version, as, on the average, it increases the antero-posterior diameter of the brim one centimeter.

One of the chief objections to the high forceps operation, apart from the fetal mortality, is the injury to the fascial attachments and support of the pelvic organs, independent of perineal laceration, which leads in after-life to sagging of the uterus, bladder and vagina, and to relaxation of the pelvic floor. Mere plastic operations on the cervix and perineum do not repair this kind of an injury, which the early application of the high forceps is liable to produce. It is an ordinary clinical experience which should lead us to follow closely the conservatism of the German school. Cases of pronounced albuminuria are notable exceptions to such conservatism. The writer is convinced that when uterine inertia first appears and progress is slow the patient should be delivered, if practicable. The extra pain and fatigue from dystocia favor the development of eclampsia.

Dystocia in the second stage of labor is often due to poor flexion and imperfect rotation of the head in either occipito-posterior or anterior positions of the vertex. The occipito-posterior positions often rotate forward when the floor of the pelvis is fairly reached, and seemingly at the very last part of a prolonged labor. Conservatism seems eminently wise, but some cases must be delivered, and it is worth while to see what can be done by a hand aided, if necessary, by one or both blades of the forceps to flex the head and very carefully to rotate the occiput just anterior to the transverse diameter of the pelvis, when the

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natural forces will complete the rotation. Flexion and rotation are the essentials for success. Push the head up a little in order to dislodge and flex it. Apply the forceps over the parietal bones, and by gentle rotation under the guidance of the hand, remembering how easy it is for the forceps to slip over the head without turning it, bring the occiput forward and re-apply the forceps for the final delivery of the head.

It has been suggested to apply the forceps with the pelvic curve reversed, to flex the head by pulling down the occiput, after which the forceps are removed and re-applied with rotation of the head. This should not be attempted except by an expert, and then only as a last resort.

Breech cases have been considered unsuitable for the use of forceps, but there are some cases with both legs extended over the body of the child where the ordinary means of delivery fail. A number of such cases have been delivered safely by forceps and the operation seems justifiable when the child's life is at stake. A forceps should be selected where the tips of the blades do not approximate as closely as with the usual instrument. It is desirable to apply the blades over the trochanters and flexed thighs rather than on the pelvis of the infant.

It may be asked why there should be so much discrepancy in maternity and private practice in the frequency with which forceps is used? It is not fair to ascribe it always to meddlesome midwifery or the convenience of the practitioner. It is more often due to the humanity of the physician, who sees his patients recover without much trouble, as he is careful of his asepsis, but he may fail to watch a record of the night or morning temperature and miss the signs of traumatism which appear later in life in the form of various uterine disorders. How many of those who operate early, in a series of one hundred cases, can show a record of no maternal mortality, better than ten per cent of infant mortality, and five out of six patients without a temperature of 100 degrees F. in the puerperal state? Until such results can be shown in a very considerable number of cases the writer is of the opinion that conservatism in the application of the forceps in the middle and superior straits of the pelvis should be the rule. We can hardly afford to ignore the results of thousands of cases which have been carefully observed and recorded.

The case is different when the head is already lodged low down on the pelvic floor. The abdominal muscles are the important, if not the principal, factors in expelling the head from the vulva. They are weakened often by over-distension or exhausted by previous contractions. In these cases the early use of short forceps to supplement the flagging forces rather than to perform a rapid extraction deserves a far wider

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use than is commonly given to it. Such an operation will diminish infant mortality. It is without danger to the mother and will save her from much needless suffering. If the perineum is firm and unusually rigid, it is a question whether it is not better to make a deep lateral incision in the vagina and perineum, deliver the child, and sew up a clean, smooth cut than to repair a ragged perineum with retracted fascia.

In conclusion permit me to urge:

I. Conservatism in operating in the superior half of the cavity or above the brim of the pelvis, except in cases of albuminuria.

II. Forceps at the brim should be reserved for the expert; version is safer for the novice, and deserves special consideration if an expert assistant is obtainable.

III. Manual reposition at the brim or in the cavity deserves more consideration than is given to it.

IV. The importance of Walcher's position in minor contraction at the brim, and the axis-traction forceps.

V. A more liberal use of the short forceps after the head is on the perineum.

DISCUSSION:

B. H. OGDEN, M. D.: The use of forceps in this high position, i. e., before the head engages, is a very dangerous procedure, and I am glad to hear Dr. Southwick emphasize the necessity of great care in their application, and perhaps the advisability of calling someone in who is an expert when such an application seems necessary; but in place of the forceps, when the expulsive pains do not make the head engage at the superior strait, version is a very favorable and not difficult operation to perform. This, of course, needs to be done under the proviso that there is not much contraction. We must not have the conjugate diameter contracted below 3¾ inches if we wish to perform version; but if the obstruction is slight, the contraction not below 3¾ inches, and the head does not engage, it seems to me version is preferable to the application of the forceps at the superior strait. The greatest danger of such application has been, in my experience, to the child, resulting sometimes from the cord falling down between the blade of the forceps and the head. I have endeavored to avoid this difficulty by placing the mother in a modified Trendelenburg position when applying the forceps.

ANDREW B. SPINNEY, M. D.: There is not much time, and as it is hard to keep in mind the statistics, it is difficult to discuss the paper; but I am heterodox and wish to refer to the doctor's use of the term extension, or rather flexion of the occiput. He evidently did not mean that. There is a big difference between flexion of the occiput and flexion of the head. When you flex the head you extend the occiput. What he meant to say was extension of the occiput. In this way, extension of the occiput would flex the head. The great secret in all cases of labor is to head reflexes. That is the point. What Dr. Ogden has said is true, regarding the advisability of version in preference to

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the high forceps, if the antero-posterior or conjugate diameter is 3¾ inches. But there are many cases where it is three inches, or a little below, and in those cases it is very difficult to perform version. Another thing which we are generally confronted with is this, which you will find to be especially true in neighborhoods where there are a great many midwives. For many years I practiced in a neighborhood where there were thirty to forty midwives, and probably in 300 cases I was called in to one-fourth of them after the midwife had been there from one day to two weeks. Now what are you going to do? Remember, you cannot perform version after the water is drawn and the pains continue to contract. You simply must perform version before the bag of water is ruptured and the water has drained away. On the other hand, the water bag is broken and the water drawn away before you apply the forceps. With this understanding, that the head is properly flexed and the head still refuses to fasten, so to speak, or to become engaged, how do you want to apply the forceps? I try to make those points clear in instructing the students. This is an old make of forceps, that you cannot apply above the brim. It is absolutely impossible to apply the forceps to the child's head above the brim and take into account anything but the pelvic curve. You cannot take into account the cephalic curve at all. In other words, it is absolutely impossible to apply the forceps in any way other than by having this come up to the side of the pelvis on each side. As a matter of fact, ninety-nine and one-half times out of a hundred of the high forceps operations I work, the head is not inclined to engage very well, the head is transverse, the occiput off to one side and the face to the other. Now that being the case, and this being true that you must think of the pelvis only under the child's head, you simply apply these to the one side of the pelvis and this to the other. Now you have secured one hold on that child's face. That is a pretty serious matter. If you are not careful, that is where the danger comes in. But you can pull that over the face; you can reach down over the chin and the other side on the occiput, and the head will become engaged. But don't you change the position of these. You cannot do it. While the head is coming down, think of the pelvic curve only. Gradually draw it down until it becomes engaged, then it changes off. If not, it will repay you to get it out and reapply it. There are many kinds of forceps, but the best high forceps is Wallace's. That is, the best I know of.

I wish to add just a few words regarding the condition the Doctor spoke of in his paper, where the pains did not come,—and that is often the case, by the way. During the first few hours, before the head engages, the pains may be hard and easily borne, and yet after a while the mother gives out. There you are! The mother stops helping you; the pain ceases. What are you going to do? There is just one remedy that is worth all the rest in the materia medica, to give in these cases, and that is strychnia. It will begin to work immediately. It is one of the greatest tonics we have. I have seen patients in labor a week probably, completely exhausted; had not had pains for several hours, and the midwife would be in a sad predicament, not knowing what to do. Speaking as little English as I can German, she would express herself like this, when I enter the room: "The baby no come; she has no pain;

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that way so long." You give 1-60 grain strychnia, four doses, maybe two or three hours apart, but after that let it alone; and I say to them, keep perfectly quiet. There is no immediate need of application of forceps until the strychnia begins to work, and it will work; you need not fear about that. I have never seen a case where it did not. But as soon as the pains begin to show, then they want to do something. Some of you will say: "Why not go at it right off?" It is not a good plan. The mother is too exhausted; she is tired out. Do not be in too big a hurry, unless there is some indication for it. I cannot understand the Doctor's statistics regarding the conservatism of the German school. Now these German physicians know how to use the forceps, and when they do use them the results are satisfactory. If they can use them after the mother is all exhausted, why are they afraid to use them while the mother has some vitality and strength? There is no question but what this is the growing tendency among the Germans—that is, for the last six months. I have read articles in which one nationality is said to be stimulated by the other. When the Germans found the French school was using the forceps, and being copied by the English and American, they began coming in.

T. Griswold Comstock, M. D.: I appreciate every statement that comes from Dr. Southwick, but the old statistics of the forceps such as were taught in Churchill's midwifery are to-day valueless. Whenever any delay occurs in a labor, and the delivery may be terminated by the use of forceps, they are indicated and should be at once applied. This is a rule that I have adopted and taught in my lectures for the past twenty years. Regarding the application of forceps when the head is at the superior strait—the "high operation"—this is an operation which should be made only after careful consideration. In such a position of the head, I always place the woman in the *Walcher posture,* with the legs pendent and, even then, I have resorted to the forceps very seldom, prefering version as being safer. I have occasionally adopted it in consultations where the attending practitioner has insisted upon it, and I have known injurious consequences in the hands of others. Personally, I have never had any mortality from the use of forceps when rightly applied. They are safe for both mother and child, and in many instances where I have used them successfully, in subsequent labors, lying-in patients have begged me to hasten the delivery by resorting to them again. Dr. Southwick mentioned the rectification of the position by the aid of forceps, and in occipito-posterior positions to introduce them *reversed.*

Some high authorities have given this advice; I have tried this plan without success, and am now opposed to it. Even such high authority as the late Professor Scanzoni, of Wuertzburg, advised it, and with his most wonderful skill and experience it may have been practical. In cases of occipito-posterior positions when the head is well down and the occiput lies fixed in the cavity of the sacrum, with the pains still active, we are advised to wait patiently, and not at once to use the forceps; because, in many such instances nature will rectify the position and bring the occiput under the pubic arch, so that the head may be delivered normally. From reliable statistics we learn that in posterior positions

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of the occiput, nature will rectify the position in ninety-seven per cent of the cases; but the other three per cent of the cases must be delivered by bringing the occiput over a greatly distended perineum. However remarkable as it may seem, I have seen rectification of the position effected by the efforts of nature alone.

The question now comes, how shall we manage the delivery of the child in these three per cent of cases where we cannot turn the occiput forward? In the progress of the labor the head has come down in a *down-grade* course, the forehead is under the arch of the pubes and the occiput lies fixed posteriorly. Such cases are among the worst and most serious that the accoucheur ever has to deal with in midwifery practice. The woman has become exhausted, the pains have ceased, she cannot deliver herself, the *vis a tergo* is gone and nature must be assisted by *vis a fronte,* and this must be effected by a resort to the forceps. To get the occiput out of its position in the cavity of the sacrum, an *up-grade* course must be adopted. The perineum is already greatly stretched, and in this position, when the occiput is forced over it, you will have in nineteen cases out of twenty a ruptured perineum,—and as our late and venerated Dr. Ludlam used to say: "Ruptured from Dan to Beer Sheba." The forceps must be applied, but before introducing them, in order to prevent an antero-posterior laceration, we must resort to the little operation of *episiotomy*—making lateral cuts in the posterior quadrant of the vulvo-vaginal outlet. Then we may apply the forceps, making at first direct traction so as to, if possible, bring down the sinciput so as to bring in sight the glabella, and then raising the handles of the forceps towards the abdomen, bring the occiput over the perineum, when a complete delivery of the head may be effected. Immediately after the birth of the child and delivery of the placenta, I suture the lateral cuts, and I have always seen them heal by first intention.

The consequences of these lateral cuts are by no means so serious as the spontaneous traumatic tear of the perineum, which as a rule is antero-posterior. I may here take occasion to remark about the operation of episiotomy that it was known and practiced by Wielding Ould in London as early as 1749, was also recommended by Michaelis, of Hamburg, in 1810, by Von Ritgen, Crede and others in Germany. In the Vienna Obstetrical Clinic, where I first learned it from my old friend and teacher, Prof. Gustav Braun (Hof Rath of Emperor Francis Joseph of Austria), it has been practiced for more than half a century; but, strange to say, until within the last fifteen years it has been little noticed by either American, French or British authorities. Dr. Lusk mentions it in his midwifery and dismisses it in the following words: "It is essentially the operation of *young practitioners,* the occasion for its employment diminishing in frequency with increasing experience." Neither Cazeaux, Ramsbotham nor Playfair mention it by name; Parvin, Dorland, Grandin and Leavitt all extol it.

Fothergill, of Edinburg, in his recent work upon midwifery, recommends it. In that classical work upon midwifery by Winckel, of Munich, translated by Dr. Clifton Edgar, I quote the following:

"The threatened destruction of the perineum is the only indication for episiotomy; this is due to the extreme narrowness of the external genitals, or to rigidity of the soft parts, or to a *faulty presentation* of

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the child. It is done to prevent extensive solution of continuity, especially *central rupture.*" In the American Text-Book of Obstetrics we find the following:

"No method yields better results for the ultimate integrity of the perineum than episiotomy, rightly timed and properly executed. The ultimate condition of the pelvic floor after episiotomy correctly performed is even better than after many natural deliveries in which the parts escape rupture." Prof. Mulheron, of Detroit, in speaking of the operation, says: "The woman should always be delivered with her perineum under close observation of the accoucheur, and when it is apparent that the parts are about to give way, the incision should be made." Furthermore, Dr. Mulheron adds: "*Episiotomy* is unquestionably one of the most important of obstetrical procedures, and its technique should be mastered by everyone who assumes to deliver a woman. So firmly am I convinced of its practicability that I believe spontaneous rupture of the perineum is absolutely inexcusable." This is a comment upon that conservative author, the late Prof. Lusk, and for his slur on episiotomy, calling it, "The young practitioner's operation"; but this was written ten years ago, and during the period of a single decade experience has taught us many advances and changes in both the science and art of obstetrics.

I am very glad that Dr. Spinney has mentioned the use of strychnia in labor where the pains are weak, insufficient and exhausting the woman's strength, ending in a complete inertia. I have adopted this practice, as mentioned by Dr. Spinney, already for several years, and am in perfect accord with him as to its safety and practicability. In an ordinary labor, where the pains are weak and insufficient, I give nitrate of strychnia in doses of 1-60 to 1-30 of a grain, and repeat the dose every two hours until I have administered some three or four doses. Time and again by its use I have seen labor pains come on and the delivery completed without the use of forceps. I have never seen the least harm from this practice, and I assure you that it is far more effectual and safer than either quinine or ergot.

G. F. Martin, M. D.: I have enjoyed this paper very much, and also Dr. Comstock's remarks. The remarks on strychnia are very apt indeed. I will say that quinine, in five and ten grain doses, will do the same thing. Application of the forceps in any operation will often stimulate the uterus. I wish to take issue with Dr. Southwick in using the forceps in the transverse position. I say it is possible. I think you could apply one blade beneath the symphisis and one back over the perineum, and get your forceps in position; and if there is room for the head to rotate without the forceps, there is room to rotate with it. It sometimes is the only thing you can do, unless you perform symphisiotomy. I have applied forceps that way on five different occasions with good results to both mother and child.

Charles N. Dunn, M. D.: It is true, as the Doctor says of quinine. It will do more. It will predispose your patient to post-partum hemorrhage.

B. H. Ogden, M. D.: I have tried quinine and find it wanting. Strychnia is far superior. I have not used quinine for several years.

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A SUCCESSFUL CASE OF ARTIFICIAL IMPREGNATION

EMILY L. HILL, M. D.
GLOVERSDALE, N. Y.

Mrs. A. J. made her first call at my office December 3rd, 1895. The following history is taken from my case-book:

American; age, thirty-two years; married ten years; menses established when quite young; the flow has always been fairly regular, and unaccompanied by severe pain. The patient has profuse leucorrhea, and cannot remember the time when she did not have backache. She has always been subject to severe headaches. Sometimes the headaches come at the time of the monthly sickness, but often come at other times. She has never been pregnant, and it is more because of her desire for children than any other reason that she came to consult me. Examination revealed a rather large, congested uterus, in a position of retro-version, combined with lateral deviation toward the right side. After several months of careful local treatments, combined with internal medication, the leucorrhea and misplacement were relieved, and her general condition much improved. But the sterility persisted. The cervical canal being rather small I advised dilatation, using the olive-tipped electrodes and the galvanic current until No. 24 could be passed quite readily. At the end of two years both myself and patient were becoming discouraged, when Gerard's work on artificial impregnation fell into my hands, and I proposed to her that we make a trial of it. Obtaining her consent, I procured an intra-uterine syringe and on the morning of October 26th, 1897, she came to my office, bringing with her the semen, which had been discharged into a wide-mouthed bottle, previously sterilized and warmed and kept as nearly as possible at body-heat. The vagina was dried with sterilized cotton, the syringe sterilized and warmed, then filled with semen, which was injected into the uterine cavity. The patient was kept in the dorsal position for one hour, when she returned home and went about her accustomed duties. Her menses were due in about a week, and at that time she came to the office complaining of nausea, and reported that for the first time in her life the menstrual flow had failed to appear. Thereafter her gestation followed a normal course. During February I was out of town for a time, and when I returned she reported that she had felt quickening, but did not note the exact date. I was summoned on July 15th, just 263 days after the operation for impregnation. Dilatation proceeded in a normal manner, but the second

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stage being unduly prolonged I applied the forceps at the superior strait and delivered a perfectly developed ten-pound girl. The child is now nearly five years old, and one of the brightest and healthiest children it has been my privilege to care for. In another case, in a neighboring city, I followed Gerard's method more closely, and was successful in causing impregnation, but the patient miscarried at the third month, the abortion probably being caused by an automobile ride.

At the close of the scientific discussions in the *Section in Obstetrics,* the following business was transacted:

JOS. P. COBB, M. D., CHAIRMAN: I wish to report the announcement made this morning, that under the revised constitution, which goes into effect this year, there is no provision for a Section in Obstetrics in the Institute, but a provision for a *Sectional Society in Obstetrics.* If we wish this branch of our work to become part of the Institute's work next year, it will be necessary for us to effect an organization at this time. Dr. B. H. Ogden was made Secretary last year, and I move that Dr. Ogden be continued as Secretary of this body.

The motion, seconded by Dr. C. B. Kinyon, unanimously prevailed.

Dr. Ogden took the chair.

DR. A. R. GRIFFITH: I move the nomination of Dr. Wm. A. Humphrey, of Toledo, O., as President.

The motion, seconded by Dr. J. P. Cobb, unanimously prevailed.

Dr. Humphrey assumed office as President of the Society.

THE PRESIDENT: There is then the election of Vice-President.

DR. J. P. COBB: I move that Dr. A. R. Southwick be made Vice-President.

The motion, duly seconded, unanimously prevailed.

DR. HUMPHREY: Is there any other business?

DR. COBB: I move that the officers we have elected have the power of perfecting the organization under the name of the *Obstetrical Society of the American Institute of Homœopathy.*

The motion, duly seconded, unanimously prevailed.

The meeting then adjourned *sine die.*

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SECTION IN

PEDOLOGY

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SECTION IN PEDOLOGY

JNO. PRENTICE RAND, M. D.
CHAIRMAN

WM. OLIN FORBES, M. D.
SECRETARY

DISEASES OF CHILDREN AND THE RELATION OF THE PHYSICAN THERETO.....JNO. PRENTICE RAND, M. D.

DISCUSSION: *Geo. Royal, M. D.; L. C. Grosvenor, M. D.; Jos. P. Cobb, M. D.; A. Eugene Austin, M. D.; Arthur Fisher, M. D.; C. S. Ames, M. D.; T. A. McCann, M. D.*

EMPYEMA IN CHILDREN.....WM. W. VAN BAUN, M. D

TONSILLAR ENLARGEMENTS AND ALLIED CONDITIONS.....
G. FORREST MARTIN, M. D

DISCUSSION: *Geo. B. Rice, M. D.; Geo. W. McDowell, M. D.; Carl J. Luyties, M. D.*

EARACHE AND DEAFNESS IN CHILDREN.. .....R. S. COPELAND, M. D.

DISCUSSION: *T. M. Patterson, M. D.; E. R. Eggleston, M. D.*

PATHOGENIC TREATMENT OF PATHOLOGIC CONDITIONS.....
BENJ. F. BAILEY, M. D.

DISCUSSION: *J. P. Sutherland, M. D.*

THE PREVALENCE OF INFANTILE MUSCULAR ATROPHY; ITS ETIOLOGY AND TREATMENT, WITH REPORT OF CASES..JOHN G. CHADWICK, M. D.

CONGENITAL SYPHILIS, AND ITS TREATMENT....WM. OLIN FORBES, M. D.

DISCUSSION: *F. W. Wood, M. D.*

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DISEASES OF CHILDREN AND THE RELATION OF THE PHYSICIAN THERETO

JNO. PRENTICE RAND, M. D.
MONSON, MASS.

LADIES AND GENTLEMEN: The section in Pedology has nothing new or startling to report. For the past year I have tried to keep my eyes open for novelties in this direction, and am sad to confess that, beyond the reiteration of old ideas in twentieth-century terms, there has little been said. I shall not, therefore, attempt anything like the ordinary *resume* of the subject, but call your attention in a brief way to a few homely thoughts that have been impressed upon me by the teachings of my own experience.

"Whom the Gods love die young" was the adage of the ancients; and when we think of the ordeals through which even babies have to pass, we would almost emphasize the expression by saying "Whom the Gods love are never born." And this leads me to the thought of the part we, as physicians, must inevitably play in the great problem of human existence. We are not only "our brother's keeper," but the keeper of his children as well, and we stand guardian, in a certain sense, over the very issues of life.

I will not burden you with the trite remark that a man's education or medical treatment should begin with his grandparents more or less remote. Few of us are ever called to prescribe for people on account of their prospective grandchildren, and rarely, very rarely, are the possibilities of children considered until conception has acually taken place.

In the treatment, then, of our subject we are forced to draw the line somewhere, and to avoid confusion between the welfare of the child, and especially that of the mother, let us draw that line at the beginning of parturition, when the physician is usually in attendance.

It is a dogma of the Catholic church that a babe has an inherent right to be born, and that in cases of necessity the life of the mother should be sacrificed to this end. Whether we assent to such an extreme proposition as this or not, we shall at least admit that a child has the right to come into the world without unnecessary interference. To be specific, a child has the right to be born without the aid of instruments, unless required for its own safety or that of the mother. I am not speaking against forceps, when needed, and I am aware that the mother whom we seek to relieve is more apt than the child to suffer from their use; but I do protest against the meddlesome practice of using forceps to save the

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time of the attendant or give him an excuse for charging an additional fee.

The bony walls of the parturient canal remain practically unchanged whether delivery is accomplished in three hours or three minutes, but the traumatic results upon the flexible cranium of the undeveloped child must be altogether different. Statistics are not readily available upon this point, but were they at hand, I am sure that some cases of epilepsy and mental deficiency could be traced to the use, perhaps to the abuse, of the obstetric forceps.

When a child is born, do not expose him unnecessarily to the sudden change of temperature. The cold air may be a good tonic to excite respiration, but a drop of thirty or forty dgrees, to an adult, would be quite a shock, while in the new born it is apt to produce "snuffles" and other catarrhal conditions, which may be more or less permanent, as has been recently emphasized by Dr. Hooker.

And when you come to tie the cord, the teachings of some authorities to the contrary notwithstanding, see that the cord is free from any indication of hernia, apply your ligature close to the navel in almost absolute proximity to the skin; then strip the cord and apply a second ligature, about one inch from the first, before leaving the case.

Prof. Burdick used to teach his classes at New York never to tie the cord at all until it had been divided and allowed to bleed for a little "to relieve the congestion of the liver and prevent the resulting jaundice," after which it was immaterial whether the cord was ligated or not.

I have never quite forgiven the Professor for such instruction. In the early days of my practice I had a very unpleasant experience from a faulty ligature, and only a few years ago I nearly lost a child five days old, from secondary hemorrhage produced by the sloughing of the cord between the umbilicus and the ligature applied in the ordinary way. This might perhaps have been prevented by a strictly antiseptic dressing —I do not know—I am sure it would not have happened had the ligature been applied nearer to the body.

As soon as possible after the birth of the child see that the eyes are properly cleansed, but don't imagine, as some teach, that a solution of silver-nitrate, which may perhaps be a necessity in dispensary practice, is needful or even desirable among the better class of patients in a rural community. It may not do positive harm, but it can surely do no good and students should be taught to discriminate between the cases that do and those that do not require its use, always remembering, if the case is at all suspicious, to use the antiseptic and give the patient the benefit of the doubt.

Among the various ills of childhood there is none perhaps more common or far-reaching in its results than the lack of normal peristaltic

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action, known as constipation. How often do we hear mothers affirm that their children are "naturally constipated," when the truth is that the habit has been wholly acquired, and that, too, through the pernicious practices of the mothers themselves.

In many communities it is still the custom to dose a new-born babe with molasses and water, to produce an early action of the bowels, and later, if the child does not have an evacuation every day, to resort to Castoria or some similar preparation to produce it. The ultimate effect of all such treatment is an aggravation of the very condition it is given to relieve, and a child who at the start was only slightly constipated or, perhaps, not at all, except in the mother's imagination, becomes hopelessly and incurably so ere we are aware.

I will not touch upon that terrible question of infant feeding. One can hardly keep up with the fashion, if he tries. Like a very kaleidoscope the preparations of malt-milk and albuminous products appear and disappear. And yet, in spite of the many "perfect foods" upon the market, I am foolish enough to believe that the old-fashioned way provided by Nature is still the best, and that the mother who nurses her child at the breast has gained something that can never be acquired by tending a sterilizer or fussing with patent baby-foods.

What not to do, in the abstract, is easier, perhaps, to determine than what to do in the concrete and individual case. A child ought not to be fed improperly, and in my opinion no child under six years should be allowed candies of any kind. Candies impair the digestion, and if a child has any gastric disturbance, or suffers from so-called "worms" predispose to an attack.

I find myself going back to the days of my childhood in the belief in intestinal parasites; only the past year a little patient of mine got rid of twenty-six stomach-worms while taking the "indicated remedy" (Santonine 1x). The smallest of these was six inches long and the largest eleven inches. I saw several of the worms myself and have no reason to doubt the word of the mother as to the number or size of the rest.

If the truth were known, I believe that many, perhaps the majority of children, are infested with parasites, but that comparatively few develop reflex symptoms as a result. All cases of adherent prepuce do not produce chorea, nor do all cases of astigmatism produce headache. The nervous susceptibility is quite as much a factor to be taken into consideration as the local irritation, and the wise physician will "take due notice thereof, and govern himself accordingly."

But there is a phase of the physicians' duties to which I wish especially to call your attention, and that is the part he or she may play in the spread and communication of contagious disease. The public, through ignorance or superstition, generally believe that a physician

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carries a "charmed life," and does not take or communicate disease like his less fortunate neighbor. How many times have I been asked, "Why don't you catch this or that contagious disease?" Invariably I reply—"It is because of the rum and tobacco I use." As I have never used either, I try to make my inquisitors understand that there is no medicine or magic about it whatever, and that a physician is just as truly a subject for contagious disease as any one else.

The public should not be deceived in regard to this matter. We may not contract the so-called "diseases of children" ourselves; most of us have already had them, and, if not, the chances are that by some freak or idiocyncrasy of Nature we are immune, but we are just as likely as anyone else to carry them to others. I never had the scarlet fever in my life, and I had practiced medicine nine years before I took the mumps, but how many times I have carried the germs of contagious disease around on my clothing and, like a retail grocer, left them from house to house, I am sure I don't know.

We are still mightily in the dark regarding the *materies morbi* of the so-called "diseases of children." Mumps, measles and scarlet fever—not one of them has yielded up its secrets. But each is a "specific disease," and each has a germ peculiar to itself. If we only knew what it is, we should be much better prepared to meet it. The typhoid germ is carried in water. The tubercle bacillus principally in the air, and both malaria and yellow fever are now believed to be communicated by the bite of the pestiferous mosquito. We have searched heaven and the infernal regions for scapegoats on which to lay the curse of communicable contagious disease, and some of us have been so utterly lacking in chivalry as to charge whatever we could not otherwise explain to the defenseless nurse. But let us at least be honest with ourselves! The fault may be with the finder after all!

Diphtheria is truly contagious, and children, we know, are very susceptible to it. Our municipal authorities do right in subjectng it to the strictest quarantine, and even their best-directed efforts may prove futile. Last year a friend of mine was working in Newark, N. J. While there he had a mild attack of diphtheria. He was not confined to his bed and, but for the order of the board of health, would not have been confined to the house. However, he submitted to the most careful disinfection of all his clothing and remained in quarantine two weeks after his recovery, waiting for the bacteriological test to give a negative result.

Three days after his return to work he was summoned to Massachusetts by the critical illness of his wife's grandmother, and, though he avoided kissing or caressing his children in any way, in just five days after his arrival his youngest, a babe of two years, came down with diphtheria and the following week his wife came down with the same

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disease. Both made beautiful recoveries under antitoxine, and I have only alluded to them to show how our most painstaking efforts to prevent contagion may be vain.

In the Hospital for Contagious Diseases at Worcester is an ante-room in which the visiting physician removes his outside clothing and robes himself in a sterilized cap and gown before making his daily round at the bedside. When his duties are over he returns to the ante-room, lays aside his hospital dress and washes his hands and face in an antiseptic solution before leaving the building.

In like manner, I believe, the general practitioner can do something to prevent the dissemination of contagious disease. Sometimes the public may demand diphtheria specialists, and scarlet fever specialists, who shall abstain from general practice and confine themselves wholly to this or that disease. But the time is not yet. Meanwhile we may do something in the right direction ourselves.

For the past three years it has been my practice to wear a long duster that buttons to the chin, while in actual attendance upon a case of diphtheria or scarlet-fever. This I leave in the outer hall and put on and remove as I enter and leave the house. When my visits are discontinued I have the garment boiled, ironed and laid aside for similar occasions in the future. I also carry an extra clinical thermometer, which I leave with the family or nurse, if she does not already have one. The method I know is far from being ideal, but it is at least a step in the right direction and easily within the reach of the general practitioner.

My feelings towards mumps and measles are altogether different from what they are towards diphtheria and scarlet fever, and were it not for the disturbance in our public schools I would take both out from under the ban of public *surveillance* and put them on the "free-list."

Almost every person is sure to have measles at some time or other, and after a single attack remains immune. The disease is very mild in children, as compared with adults, and really every child should have the mumps before he grows up or goes away from home.

Regarding mumps, especially in boys, the advantages of an early attack are still more marked. Before puberty the so-called "metastasis" is very rare; after puberty it is very common, and frequently destroys the generative function of one or both testicles. In the absence of any reliable prophylactic, and we have no prophylactic, I believe that the systematic exposure of school-children to both measles and mumps during the long summer vacation would be a truly sanitary measure. While the public is being educated up, or down, to this idea we may at least quiet any excessive exhibitions of fear regarding them.

I have not time to speak of the great responsibility of the physician in demanding for the rising generation the necessities of proper food,

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healthful exercise and abundance of pure air, and I can only touch upon our modern methods of education which stunt and stuff a child instead of developing and drawing him out. The public school question is a difficult one to solve from almost any standpoint. I used to think that our terms of schooling were altogether too long, and, for many of the pupils, I think so still, but when I considered the army of street ruffians who find restraint or wholesome instruction nowhere else, I changed my mind, and am now of the opinion that for the majority of our children twelve months in the year of schooling were none too much. In a word, I would advocate for some communities a continuous school session, with plenty of teachers, few books and only occasional recitations. Make the school do for our sweltering foreign population what the home ought to do, but cannot.

The greatest good for the greatest number is the principle that underlies our democratic form of government. Even in our staid New England villages the children of foreign parentage easily outnumber natives, while in the cities this percentage is greatly increased. The public school is the only influence capable of transforming this heterogeneous mass into respectable law-abiding citizens. For children of comfortable surroundings our schools are altogether too long now, but for the degenerate and the outcasts of our great cities schools of some kind should be maintained throughout the entire year, and I am inclined to think that some form of industrial education would be the best. But my time is more than occupied and I have only touched upon the borderland of the duties incumbent upon the medical profession towards the rising generation. We stand not alone as custodians of the public health, but guardians of the public morals as well. It is wise for our municipal authorities to subject our public schools to daily medical inspection and exclude therefrom any who are likely to communicate disease. It would be equally wise to provide some form of useful occupation for the hordes of neglected children during the long summer vacations, for bad habits and bad morals are the premonitory symptoms of physical disintegration and incurable disease.

DISCUSSION:

GEORGE ROYAL, M. D.: I have enjoyed this excellent paper, and if it were not that my old friend would forget the disagreements that occurred when we were boys, I would agree with him entirely. However, for the sake of old times, I want to disagree with him. We get different ideas, evidently, from the same teachers. I have an entirely different experience from following out the teachings of Dr. Burdick. Tie your cord first about one inch from the integument, then, next to the body as he says, as close to the integument as possible to leave nothing to slough, put on your second ligature; do not tie it; cut between

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the two; let out the blood; then tie the second ligature, if you use any at all.

Now, then, the second point. I am sorry indeed that he left it out, or rather intimated that we should have nothing to do with the grandparents of the children of future generations. I cannot agree with him at all. I am a firm believer in pre-natal medication in every form; and I am also one of those physicians who believes it is his duty to educate the people. The only way that we can come into these cases before conception is so to educate the public that we may get the confidence of the expectant parents, treat them and prepare them before we are called to the parturient bed.

Now, then, just one word more; I want to emphasize what was said at the last, the best part of the paper, which again brings up the point that physicians ought to educate the public on the lines that pertain to their health. The vicious habits that children acquire in crowded cities, because they have hours and hours to play together in the streets, are the very habits, as he says so well, that undermine their constitutions. The results of these habits we have to deal with, not only in their lives, but in the lives of their children. Yesterday, in discussing one of the papers, a gentleman said that we were not to teach the teachers in the public schools. I say most emphatically that we should teach them. I say it is the duty of the physician. I have been on school boards, and I feel sure it is the duty of a physician to teach what should be and what should not be done when the health of the child is concerned. I am in hearty accord with the twelve-months' school; let us call it a "vacation-school" for the public health. I do not know as I would use many books during vacation. Our schools are going to reach this point in regard to health of the individual, and they must be established, especially in our crowded cities. Let us assist those teachers who have seen the effect of the evil association of children crowded together in the streets. Let us help them remedy these conditions.

L. C. Grosvenor, M. D.: I would like to say one word emphasizing what Dr. Rand said with regard to vermiform affections. An old member of this Institute who has passed beyond the river some twenty years ago, in one of his beautiful little books for mothers, says, in speaking of worms: "Some people say there are no worms. They might as well say there are no children." He says: "There are many dead-shots for these worms. The trouble is, they are as likely to be dead-shots to the landlord as the tenant." The old father of the Foundlings' Home had just that terse way of stating things.

Now, there was a line here with regard to candies, and I take exception with the Doctor in regard to this, although I admire the paper very much. It is an earnest and able paper. When sugar was thirteen cents a pound, it ruined teeth and stomachs and was very injurious to children; since it is four and one-half cents a pound, it is taken freely and we have much less of certain classes of diseases than when sugar was thirteen cents. I believe in it thoroughly. I do not believe the Lord would have planted such a love in every child for sweets if sweets were poison. I indulge my own children freely with them. We have had eight of them in our home, and they are all great strapping boys

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and girls—those that are living—and I have never seen any harm from it. I believe in sweets thoroughly.

Now, there was another point that he touched upon, that was the feeding. He spoke about materials for feeding, and he made a very good point when he taught us that the only real and proper boarding place for the child is the mother's breast. That was a grand, good thing. But here is another thought. In nearly forty years of work I have had a peculiar, perhaps a "cranky" thought about it; and I remember very well twenty years ago, when in this convention I was talking about the subject, I had the whole convention by the ears—the value of perfectly regular feeding of the baby. Now, I give this formula to young mothers: "Every three hours, and once in the night, for the first three months; then every four hours, and nothing in the night." But once in a while a young mother will say: "Isn't that too military for a young baby?" "Well, I tell you what I do with my own babies, and we've had eight." Ours nurse every four hours during the day and never in the night. Now, there is a very strong reason and a very excellent reason for this. I have very little trouble with the babies during the first two years of infantile life, not nearly as much as many do, and I attribute it largely to this fact. There is a great law in nature, a law of labor and repose; of work and rest; of activity and cessation from activity. That is a universal law, and it impinges upon every living thing in the world, upon everybody, and upon every organ in every body. "O, no, Doctor; the heart never rests!" "Doesn't it?" The heart has eight hours of rest in every twenty-four. It is broken up into little short naps between the heart-beats—like the naps of a doctor, sometimes. If that law is allowed, and I think you will acknowledge it, is the stomach an exception to that law? Suppose the stomach is filled. We know that it requires from one and one-half to two hours to digest a meal, and the peptic glands are now empty. The perystalsis of the muscles of the stomach has caused fatigue, and the organ needs rest. Digestion is now complete and the pyloris relaxes its vigilance and allows the contents to pass off into the intestine. Are you going to put another meal right in there, or are those peptic glands to have an opportunity to rest and refill? Are you going to keep that little stomach working from morning to night, and from night to morning, and then wonder why we have such impaired digestion? I have followed this method in so many hundreds of cases that I feel perfectly confident in stating that it is very much more important the baby should have regular meals than that it should have particular kinds of food, though I believe the mother's breast is the God-given food for our babies.

Jos. P. Cobb, M. D.: I am very glad that this excellent paper is eliciting the discussion which it merits, and I am glad also that the different parts of it are taken up. I hope, however, that the subject of feeding, which in itself is a very large subject, shall not supplant altogether the consideration of the subjects which the essayist dwelt upon. I want to call attention to the fact that the essayist paid some attention to the care of the child during its pre-natal period; the care of the child in its relationship with other children—on the street, at home, and at school; and our care of ourselves so far as our ability to disseminate germs and infect other children is concerned. He has

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touched upon some points which are of paramount importance in this day. If we expect to have healthy children from unhealthy parents, we have got to give them pre-natal care. If we expect to educate unhealthy children with unhealthy inheritances into good specimens of manhood, we have got to take care of them during their early life; we have got to take care of them in school and out of school; not only take care of their bodies and feed them, but we must take care of their morals and habits as well.

I am glad indeed that the doctors have laid stress upon this point, and brought up something which we are not in the habit of discussing each year so much as this question of feeding. We have all, in the last two years, expressed our ideas on the subject of feeding. I do not believe any of us have very markedly changed our minds, whether we believe in methods based upon nature's principle or on some other so-called perfect food; there has, however, been very little said in the Section in Pedology in this Institute, in the last two years, upon the other wide subjects to which the essayist calls your attention. In the discussion of specific germs of infectious diseases, I cannot altogether agree with him. I would not attempt to have children infected with mumps and measles. If they are destined to escape, then I am willing to help them to escape; but I agree perfectly in regard to taking every precaution which he suggests in the prevention of the spread of diphtheria and scarlet fever. If you will go back into your own history, the history of your own practice and into history as it is written in our medical books, you will find out that the diphtheria and scarlet fever of today are not what they were twenty-five years ago; nor are they what they were ten and fifteen years ago. And why is this so? I do not believe that it is entirely because the human race has become inoculated with scarlet fever and diphtheria, but I believe it is largely because physicians have educated themselves and have educated the laity to prevent the spread and the occurrence of such direful epidemics as our attacks of twenty-five and thirty years ago.

A. Eugene Austin, M. D.: In a few years this problem would not bother us at all, for if present conditions continue there would then be no children in New York, especially among the upper classes. And I think it would be just as well to be so, because of the way our school systems are fitting the children for life; that is, the mothers let the governess bring them up, later taking them to Europe to different watering-places. The mothers also find it so much easier to use the prepared foods rather than nursing their little ones. I also wish to speak of how the teachers of New York are breaking down under their arduous work. They have too many things placed upon them. Oftentimes a man will receive his position as principal or superintendent through some political influence, having never taught a day in the classroom, and bringing his fads to bear upon the teacher. His ideas are very often far from practical or ideal. Dr. McLean of New York, known as the millionaire doctor, was once asked by his wife what was the nicest thing she could give her children, through their wealth. Her husband replied that he considered that every child that she had nursed had received what meant more than if she had given each a hundred thousand dollars.

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In New York the child seldom sees the mother, and hardly knows its father. These things must be brought out, and the profession must fight these problems. I tell you, we want more good New England horse sense in the profession.

ARTHUR FISHER, M. D.: I came in just at the time that the discussion was going on in regard to the tying of the navel-string. Unfortunately, I did not hear what was said before, but I have always been accustomed, myself, to tie the navel-string an inch or two from the navel and then two or three inches from that, and then cut between. Now, if I understand right, the doctor advocated cutting the cord off as close to the navel as possible. I cannot say that I see any advantage whatever in that, but I think there would be some disadvantage.

JNO. PRENTICE RAND, M. D.: My point was to tie the umbilical cord close to the skin; then put on the second ligature about an inch from that and cut outside the second one, leaving the two uncut.

C. S. AMES, M. D.: Dr. Rand, I wish you would state that more clearly. There are many who misunderstood you.

JNO. PRENTICE RAND, M. D.: Outside the second ligature cut the cord. That is to prevent the possibility of sloughing between the umbilicus and the ligature, an accident which happened to be in one of my cases.

A MEMBER: Do I understand you to say that you ligate the cord near the body?

JNO. PRENTICE RAND, M. D.: Yes.

A MEMBER: We are taught in our text-books that there are cases where the umbilicus is open and a loop of intestine slips in there, the same as in hernia; but it has happened in cases that a loop of intestine has been tied up, by tying the cord close to the body. For that reason it has always seemed to me best to tie it one inch or so away, to avoid hernia.

JNO. PRENTICE RAND, M. D.: If you strip the cord toward the body it will be impossible to include any hernia, and by cutting the cord short you will get rid of a lot of dead tissue and perhaps avoid a sloughing of the cord between the ligature and the navel and the consequent hemorrhage, as happened to me in the case to which I referred.

L. C. GROSVENOR, M. D.: I only wish to say one word in regard to the Doctor's remark on candy and sugar. I do not object to children eating sugar. I think sugar is proper food for the child, in reasonable amount; but there is a great difference between sugar and candy, as you buy the latter by the pound in the store; so that I would draw the line between sugar and candy. I believe in sugar, but not in candy, for children.

T. A. MCCANN, M. D.: I want to agree essentially with the paper that has been read. I think that is one of the greatest things ever read.

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I do not think anything ought to occupy the mind of this institute so much as this subject. I have not had the chance to raise as many children as Dr. Grosvenor; I have only two, having been married only three years. But I want to state that with those two little fellows there has never been one minute's sickness. I believe that there is nothing more damnable than the sugar for children of which the Doctor spoke. I believe I have earned more money in Dayton on account of bad candy than from any one other thing that has come to my hands. If we are going to feed the baby sugar let us give it first-class sugar-of-milk, if we can find it. I do not think the doctor meant to advocate the eating of candy. Still, he did not say so. My children that are fed candy promiscuously have no teeth; the teeth decay. Sugar is all right, and I believe will cure that constipated bowel the doctor spoke about, if we can get the proper amount of sugar and the proper amount of water. Then we will have no constipated baby. Mothers do not furnish these two articles as they sometimes should be furnished. I agree with Dr. Grosvenor perfectly that the baby should have its rest and its sleep. The two babies I have are getting to that age where usually they are troublesome to parents. I have never lost a night's sleep—never lost twenty-five minutes' sleep, neither has my wife—and the babies sleep within five feet of our hands. I believe it is due to bad feeding that parents lose sleep—irregular feeding, and feeding at night. The baby ought certainly never to be fed at night after it is one month old.

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EMPYEMA IN CHILDREN

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In considering empyema it will be well to emphasize the well-known but at times over-looked fact, that every case of purulent effusion has been at some time, for a longer or shorter period, a case of acute pleurisy, for it is never an entirely distinct affection arising *de novo*.

An inflammation of the pleura may occur as a primary affection, or it may be secondary to some general or local disorder, and the constitution and previous health of a child will exert a marked influence in the line of resistence to the effect of a chill or infection. The presence of a tubercular tendency or heredity, particularly of the lungs, will predispose to pleurisy, while a pleurisy appearing in previously healthy children suggests a possible tubercular origin. In pleurisy, as in all inflammatory conditions in children, there seems to be a special tendency to suppuration. Acute purulent pleurisy of tubercular origin, however, is rarely met with, and a purulent pleurisy, even in a tubercular child, is not necessarily of tubercular origin, as it may be either streptococcal or pneumococcal. Many of the protracted cases are due to tuberculosis, and the possible presence of tubercle bacilli must be borne in mind in estimating the future of the patient.

Empyema in children is much more common than serous effusion, and the younger the child the greater the likelihood that the effusion is purulent. It is an acute infection following the acute infectious diseases, tonsillitis, chronic gastric catarrh, mediastinal abscesses, *etc.* It is relatively much more frequent than in adults, and is more fatal. As a rule, the whole pleura is involved, encysted empyemas in infants and young children being rare. It is usually unilateral, but it frequently affects both pleuræ, the part involved corresponding with the lower lobe of the lung. In children with pneumonias which do not resolve promptly, with the auscultatory sounds becoming distant, empyema is to be looked for.

ETIOLOGY.—The great majority of cases of empyema in children, especially in those under five years of age, occur with or following pneumonia. Recent bacteriological research with pleural effusions has done much to clear up the etiology of the question, and has led to the following classification of the different varieties:

1. Pneumococcus pleurisy.
2. Streptococcus pleurisy.
3. Saprogenic pleurisy.
4. Tubercular pleurisy.
5. Staphylococcus pleurisy.

Practically we can reduce these to three types of cases: 1st, those containing the pneumococcus. This class includes by far the larger

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number of cases of empyema occurring in childhood, nearly or quite sixty per cent. 2nd, those containing the pyogenic germs, particularly the streptococcus and staphylococcus, which are found either alone or are more usually associated with pneumococcus. They are found alone with the pleurisies following ruptures of abscesses into the pleural cavity, and in anemia. 3rd, cases due to tuberculosis. These are rare in early childhood, but become more frequent after the seventh year. The presence of the tubercle bacillus is difficult to demonstrate, and the possible tubercular nature of the pleurisy may be overlooked, even in a hasty post-mortem, for inflammatory exudate may mask the presence of an acute miliary tuberculosis of the serous membrane, and the observer may neglect to examine closely the condition of the inter-lobar fissures, the exposed surfaces of which usually become agglutinated at an early period of the disease, and on separating, if tubercles are present, each granulation will appear distinct and clear-cut as when first formed, as no deposit or exudate has been able to collect over them (Fowler). In this connection it is interesting to note that the exudate of the variety due to pneumococcus is thick and creamy, considerable in quantity, and compresses the lungs, but there is very little thickening of the pleura. That associated with or due to the streptococcus or staphylococcus is thinner, less in quantity and the pleura is thick. While that of tubercular origin, found in protracted cases, is scanty, and there is considerable thickening of the pleura.

The exudate in infants and children has the appearance of pus, thick, creamy and odorless. In some instances it consists of a cloudy serum, which investigation will show to be purulent. The quantity, while it may be enormous, is usually remarkably small, even in fatal cases not more than seven or eight ounces. Sacculation is much more frequent than in adults, and encapsulation of the fluid is most apt to occur between the lobes of the lung.

Symptoms.—There are no pathognomonic symptoms of empyema. The symptoms of the primary disease usually predominate, and a persistent elevated temperature and rapid pulse after pneumonia is strongly suggestive of empyema. Sometimes pneumonia and empyema are concurrent, and give rise to a series of grave symptoms. Again, a pneumonia, or other infectious condition followed by exhausting sweats, with a distinctly intermittent temperature and an increasing frequency of respiration, points strongly to the existence of a suppurative pleurisy.

Chills are absent in a large number of cases, the initial symptom being vomiting, headache or convulsions. Pulsation of pleural effusion is rare, and its presence is limited to left-sided empyemata. Edema of the affected side is seldom met with, unless in old-standing cases, yet it is much more apt to occur in children than in adults. It may be pres-

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ent in very acute septic cases. In protracted cases there may be extreme emaciation, profuse perspiration, repeated rigors, febrile urine, increasing anemia, sallow complexion, annoying cough, with rapid respiration; pointing, rupture of the sac, or, very rarely, absorption in some pneumococcus cases. So the symptom group is not distinctive.

The *course* and *termination* are variable. An effusion may continue to increase in quantity from five to fifteen days, then the inflammatory process ceases and absorption starts in. Absorption rarely takes place during the continuance of considerable fever, and the presence of pus prolongs the duration of the illness. The nature of the effusion and the degree of the thickening of the visceral layer of the pleura are the chief factors determining the re-expansion of the lungs.

The result is hard to estimate, for even after an effusion has been purulent for six months or more, complete re-expansion may take place, following a paracentesis.

DIAGNOSIS.—The signs of fluid in the chest of a child are different from those found in an adult, and the greater the effusion the more difficult the diagnosis, for the pleural cavity may be filled with fluid and the voice and respiratory murmur may be only slightly diminished, both anteriorly and posteriorly. Again, in partially filled pleural cavities the respiratory sounds are supposed to be weak or absent below the level of the fluid, but in many a child tubular breathing will be audible over the whole of the dull area, and is frequently a source of error.

In certain localities the diagnosis of fluid must be made with reserve. The presence of fluid admitted, the differentiation of pus and serum becomes a serious problem. The necessity of determining beforehand the character of the fluid present is apparent, for if it is not pus, interference surgically is not necessary, unless the accumulation of the fluid is rapid and excessive, giving rise to distressing dyspnea, marked cyanosis, great cardiac displacement and aggravated associate symptoms, such as harrassing cough, intense intercostal pain, exhausting sweats, rapid emaciation, etc., which is seldom the case in childhood, otherwise the serous effusion will take care of itself, and should it be of tubercular origin conservative treatment demands that interference should be postponed as long as possible, for removal of the fluid seems to be hurtful to the case. Pus being present, surgery is in order. In all cases the presence and character of the fluid should be positively demonstrated by an exploratory puncture, done with the patient in the upright position. If no fluid is obtained at the first attempt and the symptoms continue unabated, another exploratory puncture should be made.

The fluoroscope is now claimed to give even more positive results than puncture, the picture being especially characteristic of empyema when pulsation of the fluid is visible on shaking the patient.

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The prognosis is as a rule favorable, especially when an early diagnosis has been made and approved methods of treatment have been instituted.

TREATMENT.—The inflammatory remedies are called for in the beginning, and pus remedies later. It is dangerous to allow empyema in children to run on to a spontaneous opening, for practically recovery never takes place under such circumstances; in fact, death often occurs before pointing has made a bad surgical operation. The moment the presence of pus is established the case becomes a surgical one, and should be so handled, and the old surgical axiom holds good: In the presence of pus, let it out.

Aspiration or operation must now be selected, and in making a decision it must be borne in mind that aspiration is not always trivial in its results, death having been reported in some instances. If the case is not urgent, aspiration may be employed, provided radical operative measures are not delayed too long if the progress of the patient does not prove satisfactory. In very young children simple puncture may be followed by prompt recovery by absorption, even if only a comparatively small amount of fluid is removed. The average case, however, calls for operation. An empyema should not be permitted to continue until it causes compression of the lungs, for the tendency is to become encysted.

OPERATION.—The ordinary operation is to excise under anesthesia about an inch and a half of the eighth rib in the posterior axiliary line. The pus and coagula are allowed to escape, and then a large absorbent dressing is applied. In protracted cases portions of the chest wall are removed according to the methods of Estlander and Schede. In some instances a portion of the thickened pleura has been stripped from the lung, in order to allow a better expansion, the advantages of this being less deformity and a hastened convalescence. It is to be remembered that dangerously profuse hemorrhages have occurred on incising a thickened pleura. The complication most to be feared medically after an operation is a broncho-pneumonia, which may either be due to a dormant condition at the time of operation, now asserting itself, or to a direct infection.

Expansion is a question of vital importance. Some surgeons advocate that the anesthesia should be stopped on exposing the pleura, and the finger used to break up any recent adhesion. The lung then expands, and the child wakening cries or coughs and so assists in a remarkable manner in the expansion of the affected lung. Old adhesions are obdurate, and require the more radical interference of an Estlander operation.

The patient should be encouraged to sit up as soon as possible and

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expansion favored by forcing air from the sound lung into the diseased one. This occurs on coughing, and if the patient will take a deep breath and try to make a forcible expiration while holding the nostrils with the mouth closed, the dilating effect will be greatly increased. The value of this method is it requires no instrument and can be done frequently every day. The expansion may also be favored by having the child blow through a tube, forcing water from one bottle to another. It is claimed that expansion is increased materially by the use of a rubber valve over the opening made in the chest. The former practice of freely irrigating the pleural cavity is to be condemned, because it serves to break up adhesions now desired after operation, and it does not seem to shorten the period of recovery, and if repeated frequently may result in permanent fistula.

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TONSILLAR ENLARGEMENTS AND ALLIED CONDITIONS

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While my subject is not a new one, it is far from being worn out. Had I known, when I selected this subject for a paper, that one of the branch societies of this Institute devoted an entire session to the consideration of practically this same subject at last year's meeting, possibly I might have made a different selection. And yet the above fact does but serve to emphasize the importance of the theme. Furthermore, it is my desire not to handle the question in the minute and technical manner in which it was considered by the specialists above referred to, but to speak as a general practitioner, and to deal with the question as it must present itself daily to each and all of you. To those especially interested, however, I commend the papers of Drs. Rice, Townsend and the others, as well worthy of a careful reading.

Enlarged tonsils and their frequent allies, pharyngeal "adenoids," are of very frequent occurrence, and I think that their potency as disturbers of the general health is not sufficiently appreciated. I intend to limit this discussion to a consideration of these two obstructions only, because, if the whole field of foreign structures in the nose and throat were opened up, we should get into too deep water for our bureau.

The tonsils lie on either side of the throat in a recess formed by the divergence of the anterior and posterior pillars of the soft palate as they pass downward from the uvula. They vary somewhat in size, averaging about one-half by one inch. They should not project into the throat beyond the pillars. Their buccal surface is punctured by some fifteen crypts, and is covered by mucous membrane which dips into each of the depressions. They are compound follicular glands, containing a number of aggregations of lymphoid tissue, similar to the solitary glands of the intestines. They have a fibrous capsule. The secretion of the tonsils, in the crypts, is mucous and lymphoid. The blood-supply and lymphatic circulation are both rich.

The second structures we are considering, "adenoids," are usually situated in the vault of the pharynx. A certain amount of lymphoid tissue is normally present in this location, constituting what is known as Luschka's tonsil. It is to the *hypertrophy* of this tissue that the term "adenoids" really applies. Even this term is somewhat misleading, as the tissue is not strictly an adenoma. But it has acquired usage, and this gives it a significance. For our purpose, the general structure of the

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two parts can be considered as identical, although the "adenoids" are softer and more jelly-like than the tonsils.

This brief description will suffice to bring before our minds the anatomical parts we desire to consider. It will be seen that, in health, they offer no obstruction in the buccal passages, and in no way interfere with speech, respiration or smell.

The particular seat of these structures, just at the "drop" of the nasal and mouth passages into the pharynx, makes them peculiarly liable to irritation from various inhaled and swallowed substances. And in practice we find that they *are* the frequent seats of inflammation and disease. This is particularly true of the tonsils. In our practice among children, no disease is more common than tonsillitis of one form or another. And while these repeated attacks in a child seem almost always to lead to a hypertrophy of the parts, this condition will sometimes be found where no history of previous acute disease can be elicited.

"Adenoids" and diseased tonsils seem, in many cases, to have some relationship with the development of tuberculosis. Let us look at this feature a moment. We have found that the adenoid tissue is very vascular, and of a low form of development, hence of low resisting power. We find that tonsils, perhaps placed as safe-guard (at the portals of the lungs and stomach in health), are far from that when hypertrophied and diseased. Especially in follicular tonsillitis (formerly often called "diphtheritic sore-throat") do they become traitors at the door, rather than faithful sentinels. We find the secretions of the crypts becoming inspissated, and forming yellowish-white plugs of false-membrane over the surface of the tonsil. In hypertrophy, these dry secretions, mixed with broken-down cells, become cheesy, decompose, and emit a putrid odor from the breath.

Can two more ideal conditions be imagined for the reception, propagation and distribution of the germs of disease and their products? The deeper of these crypts have direct lymphatic connection with the glands of the neck, and evidence is rapidly accumulating, as methods of observation and study improve, that tubercular cervical adenitis, and perhaps deeper-seated tubercular desposits, can be directly traced to an infection first received upon these beds of filth in the mouth. The infectious nature and germ-cause of tuberculosis are well established, and I believe that no point in connection with the study of this dread disease is more pregnant with possibilities for good results than is a careful attention to these structures within the mouth. What is true of tuberculosis applies also to diphtheria, scarlet fever, and other infections. The liability to *all* inhaled infections is greatly increased by the conditions outlined.

But to return, the conditions for which the physician is most fre-

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quently consulted are those which the parents themselves have noticed, those due to obstruction. This is of all degrees, and the symptoms produced vary accordingly. Hypertrophies of the tonsils as large as an average English walnut have been seen by the writer, and the adenoid accumulation varies from a simple congestion to a number of spoonfuls of the "bloody jelly."

One writer to whom I have referred makes the following rule: "Tonsils which project beyond the pillars are diseased, and need removal." I would call attention to an exception to this rule. In those cases where a tonsil has enlarged to a considerable extent, but has carried the anterior pillar of the palate forward and also inward towards the mouth, the tonsil may be much larger and much more in need of treatment than in other cases, where it is smaller, and yet projects far beyond the pillar. The pillar may or may not be adherent to the tonsil, but we see many cases in which it bulges forward and inward to a marked degree. These cases are difficult ones to handle.

The frequency with which "adenoids" occur is difficult to state in figures, because authorities vary so widely in their estimates. All agree, however, that it is essentially a trouble of early life, seventy per cent of all cases occurring before the fifteenth year of life.

The acute attacks of inflammation of tonsils and of "adenoids" may come and go, have their little cycle of fever and general disturbance, yield readily to treatment, and disappear. It is with the chronic enlargements that we are most interested. Here we find mechanical interference with the passage of air through the naso-pharynx, often interference with the ventilation of the middle ear, because of an extension of the growth which causes pressure upon the entrance to the Eustachian tube, and interference with normal speech, the voice becoming rather thick and husky because nature's resonating chamber is filled up. The child lacks oxygen, and the air which it does get, being inhaled through the mouth, cannot be filtered as the nose would do it, and cannot be warmed as the arterial loops in the turbinated radiators would warm it.

Such air is an irritant to the sensitive membrane lining the throat and bronchi. Because of the obstruction in aggravated cases every inspiration is a violent muscular effort, calling into play the throat and even the shoulder muscles, almost as in asthma.

The thorax cannot develop properly, and such children are often "pigeon breasted." The alae nasi are contracted, and the nasal chambers are all smaller than normal. If in a young child, the palatal arch becomes narrow and the alveolar arch is a narrow ellipse instead of a semi-circle. The teeth are thus much crowded, and are apt to be pushed out of line to a considerable extent. The upper lip is drawn up. The

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sense of smell is more or less interfered with, and there is usually considerable nasal discharge from both the anterior and posterior nares. Ear-symptoms may be acute, such as frequent earaches, with attacks of purulent otitis media. Or, they may take the form of progressive diminution of hearing. Many a child in school is classed as stupid when his real trouble is a failure to hear what is said to him from this cause. In this connection, however, it must not be denied that an actual inaptitude for mental work is a common result of these growths. A diagnosis of "stupidity" is certainly favored by the facial expression which accompanies this defect. The open mouth, with hanging jaw, dull eyes and general listless look, are a part of every case. These children are mouth-breathers, with all that this implies. All symptoms are aggravated during sleep, when, owing to the general relaxation of the throat-muscles which then occurs, the tongue settles back against the swollen tonsils like a ball valve, and, as a result, respiration is greatly embarrassed. Night-terrors are common, and aside from the fright, the child is often seen to spring suddenly up in bed when sound asleep, in order, by a change of position, to get a breath. The sleep does not refresh and the child grows pale, anemic and wasted. The sleep is snoring, noisy and catchy.

It would seem as if this picture would furnish us with sufficient data on which to establish a diagnosis, without further inspection. But this would hardly be in conformity with modern methods of exactitude.

With a good light, and the mouth of the patient wide open, the tonsils can often be seen. If not, the tongue-depressor will be required. When the child gags, and they almost invariably do, the tongue will be drawn quickly downwards, the tonsils pushed into the throat by the contraction of the pharyngeal muscles, which lie underneath them, and the desired information about their size and condition is at once obtained.

If the observer is alert, he may, in this same swallowing act, notice that a lump of slimy, muco-purulent matter is pushed downward from the naso-pharynx as the muscles contract about it. This can be accepted as presumptive evidence of the presence of "adenoids" above. If too high up to be seen, they may be brought into view by hooking forward the uvula. Failing in this, to obtain satisfaction, the throat-mirror may be called into play in older children and adults. But I have had little success with it in young children. The carefully cleansed finger is the most satisfactory instrument of diagnosis in this class. If the child is too young to reason with, my method has been to take it upon my left knee, pass my left arm around its head and left shoulder, which is thus firmly but gently pressed against my chest. Directing the child to open his mouth, his left cheek is immediately pushed between his teeth and held there by a finger of my left hand. The right fore-

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finger now passes up behind the uvula, and the diagnosis is quickly made. No gag or clumsy towels about the finger are needed for this examination, and if you hold the child's head firmly, you will never be bitten. The child's hands, and, if need be, the feet, are held by the parent or assistant. There is not the slightest roughness or harshness about this method. Care is necessary that the uvula and polypi projecting from the posterior nares be not confounded with "adenoids." The point of attachment should be sought for.

Now, I have often heard specialists criticized for finding too many troubles present in a patient, due to some lesion in the particular organ on which they "played." And I might be criticized for the direful pictures I have presented as caused by these pesky little lumps in the throat, were I not prepared to assert with positiveness that not one of them is too highly colored or overdrawn. As physician to the Ayer Home for Children for the past nine years, where many of the little waifs have, on admission, the most depraved of constitutions, and after a personal experience with several hundred cases of disease of this kind, I am only too ready to add my endorsement to the writings of so many other observers, who emphasize the necessity of close attention to these troublesome growths.

The prognosis is always *bad* unless something be done to relieve the obstruction. I am well aware that these growths have a tendency to disappear around the age of puberty, and that they are comparatively rare in adult life. But I cannot follow those teachers who advocate letting them alone, and "giving nature a chance," on this account! For the damage which they do in childhood remains behind long after the growths themselves have shrunken and disappeared. And it is not *now* remediable! The mouth-breathing habit has become established, the tendency to bad throats and troublesome lung conditions is there to stay. The high-arched palate and crowded teeth remain. If the ear has been involved, purulent otitis media has left its permanent stamp, with destruction of the drum and ossicles, deafness, and all the troubles which naturally follow such a result.

Be honest with your patients and you will tell them that the growths may disappear of themselves in time, but that the results will surely remain. Treatment of some sort is an imperative duty.

TREATMENT.—I have already remarked that we seldom see these cases until symptoms of obstruction have called the attention of the parents to the presence of some trouble. And such cases are unusually far advanced! But if called early enough, before the growths have become of sufficient size to impede respiration and swallowing, I certainly consider that we can do much good with our remedies, and perhaps prevent further trouble.

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In enlarged but not badly diseased tonsils, I have repeatedly seen good results follow the administration of *baryta carb.*, 12x, twice a day for several months. Swelling and accompanying disturbances have improved under its use, and no further treatment is required.

The *calcareas,* carbonate and iodide, are valuable remedies, especially in children with general lymphatic and glandular involvement.

Guaiacum and *phytolacca* are helpful in enlarged tonsils, accompanied, as diseased tonsils so often are, by rheumatic manifestations in other parts of the body.

The whole constitutional condition must be considered in selecting the remedy, just as it must be in picking the nourishment. Nutrition is below par in these cases, and careful attention to diet, to baths, and to every detail of the hygienic and sanitary surroundings will be needed if we would get our best results.

Mild antiseptic, alkaline gargles or sprays, such as diluted Listerine, formalin, Dobell's solution, *etc.,* are often an aid to our internal treatment, particularly if there exists any offensive condition in the area, which makes every inhalation an offense against the lungs.

Applications of various solutions to the tonsils have been recommended, and some good results obtained by their use. The basis of most of these is the contained *iodine.*

The application of *iodine* by means of the galvanic current has been recommended, the positive pole, dipped in iodine, being applied directly to the tonsil, the negative on the outside of the neck.

It is to be regretted that all of our cases could not be seen in the stage where such measures will avail. For I am fully convinced that, with rare exceptions, if hypertrophic conditions and the mouth-breathing habit have become well established, there will be something more than medicine required to relieve the patient. While some of these advanced conditions are undoubtedly *helped* by a prolonged course of treatment, still, as I have previously pointed out, valuable time is being lost, during which, deformity is rapidly developing.

Is the result worth the price paid for it? I think not! But let us see. The principal objections that I have heard raised against operative measures upon these growths, are, (1) that the tonsils were put there at birth, by "nature," have their uses in the economy, and hence evil must result from their absence, (2) (and this objection I find strongly urged in a prominent work on Diseases of Children) that, after the removal of the tonsils, the child is much more liable to glandular disease. Tuberculosis in other parts of the body is especially noted by this writer. He further states that he has repeatedly seen tubercular disease appear in the neck and lungs soon after the removal of diseased

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tonsils. (3) That they can be cured just as well by remedies, *etc., etc.* (4) That they will disappear of themselves in time.

To the first of these I would reply that "nature" never put a diseased structure anywhere for a purpose. We are not dealing with *healthy* tonsils, either pharyngeal or naso-pharyngeal. Physicians are not consulted about these. Were the same amount of disease present on any external part of the body, where it would not be one-half the menace to health that it is here, we would know it at once, and never stop to question the wisdom of the step. Whatever valuable function these two collections of lymphoid tissue may originally have, it is not safe to trust them to continue such work when they become diseased.

It seems to me that, in the second objection, the writer has correctly stated facts, but erred in the conclusions drawn. In the light of our present knowledge, is it not probable that, instead of furnishing us a reason for *not* operating, the writer has rather given us a good argument in favor of *earlier* operation?

The absorption into the open crypts, and distribution therefrom to other glands, has occurred before the operation was undertaken. It is not in accord with modern scientific knowledge to maintain that to remove a bed of disease in one location, and clean up and purify the spot on which it reposed, can be the cause of a recrudescence of the same disease in another location.

In answer to the third claim, I can only say that earnest efforts on my part have failed to give me such results, except in the early stages, and in exceptional cases of more advanced disease, and a rather careful perusal of the writings and opinions of others fails to find many who *do* so believe.

The fourth objection has already been covered, earlier in this paper, when we described the anatomical bony changes and other deformities resulting from delay.

We seem to come down, then, to operation for removal as the proper treatment for the majority of cases.

I shall not go into the full details of the methods of removal. The snare, the cautery, the bistoury and the tonsillotome, all have their advocates in tonsil work. And in "adenoids" the finger-nail, the artificial nail, the curette and the forceps, of various designs, are used by various operators.

For myself I have found the Gottstein curette suitable for all but the fibroid form of "adenoids," and these cannot be strictly called "adenoids," and my work on the tonsils has been done almost entirely with the tonsillotome. It is my custom to scrape away all I can find of the former material, and to trim the latter down as evenly as possible to the underlying muscle of the throat, so that they no longer offer an

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obstruction to breathing or swallowing. If the base bleeds profusely, a compress saturated with hydrogen peroxide and held against it for a few seconds offers an excellent styptic and disinfectant, which is usually quite sufficient.

Tannic acid or *adrenalin* solution may come in if a stronger action is required. After treatment little is necessary locally, and in four or five days the parts are usually well healed. Avoidance of acrid or very *hot* foods for a few days, and rest in bed for twenty-four to forty-eight hours are advisable. Relief is immediate, and harm never results from a careful and proper operation.

Now, in closing, let me say further, that I am second to no man in my loyalty to homœopathic therapeutics, if such use of remedies is limited to the therapeutic sphere of action.

But I do not believe that either the system we practice and admire or the well-being of our patients is well served by attempting to accomplish mechanical results with potenized remedies. And the practice of careful removal of these mechanical obstructions, in all but simple cases, will leave our patients in far better condition to respond to our carefully selected treatment, which we can now apply with better hope of success. The operation, however, should be used only to clear the field for judicious after-care.

DISCUSSION:

GEORGE B. RICE, M. D.: Members of the Institute—I wish to confine my discussion of this interesting and very complete paper to two portions of the subject, namely, the necessity for the removal of enlarged faucial and pharyngeal tonsils by surgical means, and the methods of performing the operation.

It has been argued again and again that the tonsils were important functional organs, and that removal of them was sure to do harm to the patient. I should like to call attention, first, to the established fact that the tonsil in its normal state is an exceedingly small mass of lymphoid tissue. The healthy pharyngeal tonsil cannot be readily seen, except by the most careful rhinoscopic examination, nor the faucial, except by pulling aside the anterior faucial pillars.

The size of the faucial tonsil has been estimated to be about that of half a small white bean, possibly a little larger, and the pharyngeal tonsil to be simply a thin diffuse congregation of lymphoid tissue, not more than one-half an inch at its greatest diameter, and situated on the upper posterior portion of the naso-pharyngeal space. Unless these are rudimentary organs, as some good authorities believe, they without doubt have a function, but no one knows what this function is. We have only numerous theories covering quite a wide range of ideas.

Now the point I wish to insist upon is this, that whatever this function is, or may have been, that it is lost in the process of hypertrophy. This is so for reasons which can be readily demonstrated.

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The normal tonsils are homogeneous lymph-structures, morphologically similar to Peyer's patches in the intestinal tract. They are simply interlaced connective-tissue fibres, the meshes of which contain rounded granular lymph-corpuscles. In inflammation of these structures, Franckel found that the changes which occurred were increased migration of leucocytes, and Goodale, that the cells of the tonsil and mucous membrane covering showed active proliferation, and that where the tonsil had been repeatedly inflamed, were found foci of suppuration in the follicles, the crypts and follicles becoming dilated, fibrous, and the connective-tissue increased, and in the small openings formed, numerous bacteria. Several authorities have discovered tuberculous bacilli in at least twenty per cent of a large number of specimens examined, and streptococci were frequent.

In the investigations carried on by Dr. Griffith and myself, we found that the fibrous and connective-tissue is nearly always increased in the process of hypertrophy. These fibres are often arranged in bundles, crushing out entirely the true lymphoid tissue which may have been embedded in them. Again, as in the large soft tonsils, the original lymphoid tissue has been replaced by a large-celled hyperplasia, the connective tissue being scattered through the mass. In some specimens were found infiltration of epithleoid cells, and areas where the blood-vessels were increased markedly. One specimen showed the lymph sinuses filled with pus-cells and debris.

I will not weary you by a more detailed account of these microscopical studies. The tissue taken for examination was not especially selected, but over sixty specimens were examined as removed from the throat in the course of my regular operative work.

To the impartial investigator but one conclusion can be arrived at regarding these structures, namely, that stated in the beginning of this discussion, that if the tonsils have a function, this function is lost in the process of hypertrophy, and that the enlarged diseased mass becomes a pathological growth which is a constant menace to the patient's health and vitality.

The selection of the method of operation for the removal of these hypertrophies must be governed by the age of the patient, and by the shape and size of the growths. As a rule, faucial tonsils which have been repeatedly inflamed are adherent to the faucial pillars.

An attempt to remove them before freeing the tonsil from these adhesions would result usually in either injuring the palato-glossus and palato-pharyngeus muscles forming the pillars, or in leaving a rough, irritable stump, which would be more likely to prove a source of inflammation and infection than the original growth. Even after separating these adhesions, it is not always possible to remove all of the diseased tissue by means of the instruments ordinarily used, the tonsillotome and guillotine. The long flat growths cannot be engaged in the lumen of the instrument, and therefore nothing will be accomplished. In these cases the only satisfactory method is to pull forward the mass with forceps, and to carefully dissect it out with dull saw-toothed scissors, perhaps finishing the work with a small tonsillar punch. Frequent applications of *adrenalin* 1-1000, will effectually control the bleeding, and

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allow the dissection to be carried out with greater nicety. In most adults a local anesthetic will be found satisfactory, but in children, and in very nervous individuals, a general anesthetic becomes necessary.

After trying the various positions recommended I have for some years operated with the patient lying flat on the table, half over on the chest, where the head can be slightly raised and held by an assistant, then, with a good light, and a head-mirror, and a self-retaining tongue-depressor, the work can be easily done. The naso-pharyngeal growth if present, can be removed at the same time, and my favorite instrument is a wide modified Gottstein curette. Forceps I almost never use. Occasionally circumscribed growths can best be amputated by a guillotine so constructed as to conform to the outlines of the naso-pharynx. Small masses left in the fossa of Rossenmueller can be removed by the finger usually. I think it quite important that all of the lymphoid tissue possible should be taken away; otherwise, in the markedly strumous child a rapid recurrence is probable.

We too often forget, I think, that children suffering from these growths need careful and persistent constitutional remedial treatment, both before and after the operation. I presume that it is sometimes possible to cause absorption of the soft tonsils by the use of internal remedies, but I have yet to see a case satisfactorily treated by this means alone. Absorption gradually takes place in the majority of cases by nature's methods, but the process is so long that by the time it is completed much harm has been done.

George W. McDowell, M. D.: This is an important matter; one that interests every man who treats ears. It is of vital importance in preserving the integrity of the ear to treat enlarged tonsils, and especially hypertrophy of Luschka's tonsil in early life. As the essayist has well said, frequently the hypertrophy of Luschka's tonsil will disappear at the age of puberty; but at that time the damage in many cases has been largely done. The train of pathological changes has been started, which will go on to maturity and end usually in a chronic catarrhal condition of the middle ear with largely reduced hearing power, or possibly in a chronic suppurative condition which may end in death. We never know where a suppurative condition of the middle ear will end. The old rule that chronic suppuration of the middle ear will cure itself if left long enough has proved fallacious by many years of observation by many men in this field. I have seen cases that had been discharging from ten to thirty years. Usually at the end of ten or thirty years, as the case may be, we find a caries of the ossicles, the caries often extending into the tympanic vault, and a chronic suppurative condition resulting that not even the most careful and painstaking treatment locally and internally can remedy. Usually those cases come to an operation of one kind or another. It may be necessary only to remove the adenoid tissue in the early stage. In children who have had suppuration in the middle ear for five years, with the presence of enlarged Luschka's tonsil, the suppuration has ceased in a very few weeks after the removal of the adenoids, where it had previously resisted all forms of treatment, both locally and internally.

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Chronic suppuration may have commenced originally, possibly, as the immediate result of scarlet fever or measles; but, probably because of this underlying condition of hypertrophied adenoid tissue in the vault of the pharynx which predisposes to inflammation in that region, these cases at the end of a good many years have left conditions which are not easy to cure by any means. Sometimes the result in adults is a chronic catarrhal condition, with adhesions of the ossicles, in-drawn drumhead, thickened and impossible to vibrate, the hearing being reduced to the minimum; all manner of treatment is unavailing to mobilize the stapes, which has become fixed at this period, or to stimulate a healthy condition in the tympanic cavity. These cases are usually not responsive to any operative measures.

Removal of the whole chain of bones, removal of the tympanic membrane, does not in the majority of cases relieve the trouble, as it will in some instances; but this difficulty, after long continuance, has gone on further than the middle ear, and, in fact, the nerve itself is affected, so that any measures tending to improve the local condition in the middle ear are useless. Therefore, I am an advocate of the early treatment of both enlarged tonsils and adenoids. If you get the case early in life it often responds to the internal remedy, and that has to be very carefully selected, depending not on the characteristics of the growths themselves, but on the general condition of the patient. But as these cases usually come to you when they are far advanced, tissue changes often well marked, tonsils hard and fibrous, and the conditions in the middle ear resulting from the enlarged adenoid tissue well established, I do not believe in waiting for further change in the tonsil tissue, either in the pharynx or in the vault. I believe, then, the best thing to do to preserve the integrity of the hearing organ is immediate removal of the offending tissue.

As regards method of removal, the essayist has referred to the simple method of scraping out the adenoids with the finger-nail. That, I think, is only to be spoken of to be deprecated. It is an unscientific as well as a septic procedure. We all know our finger-nails carry innumerable germs, and sterilize and cleanse them as we will, cultures made from them always show the presence of germs. So that even if the process were thoroughly capable of being carried out with good results, it should be prohibited on account of the infection liable to follow. In making the operation, I think the only proper way is to put the patient under a general anesthetic. Then the whole vault of the pharynx can be carefully examined, the location of the adenoids determined, and the operation proceeded with carefully, so that the entire field can be made smooth and clean. Previous to making an operation, I think it is quite requisite that we should sterilize the field of operation; and this is a matter that has been neglected too much. In the last two years I have read in home and foreign journals of three cases of septic meningitis resulting from the removal of adenoids. Undoubtedly this infection resulted from the fact that the field of operation was not previously sterilized, and, having a large raw surface following the operation, the disease-germs were easily absorbed and the infection carried to the cerebral tissue. It has been my custom since this has been brought to my notice to sterilize the field of operation by means of

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the post-nasal syringe, using normal salt or bi-chloride or electrozone solution before the operation, and immediately afterward repeating the procedure. I have never had cause to regret this extra care, and it takes but a moment of time.

I think the important thing is to insist upon the necessity of general anesthesia. It seems to me to be unkind, to say the least, to take advantage of our position as men to compel helpless children to submit to an operation at which any one of us would revolt. I do not think any man or woman in this audience would be willing to have his tonsils removed in that way. One gentleman who had this done told me he felt as if the top of his head was being scraped off; and to a child of sensitive nature it is a shock from which I believe they rarely recover. They not only acquire an antipathy to the particular doctor, but a repugnance to all measures applied to their general physical improvement, and it would be hard to persuade such a child to have anything else done that might be necessary to do in the way of an operation. The anesthetic being given, the operation is performed quietly, without any haste on the part of the operator, and in such manner that he can make sure that all of the tissue has been removed; the child recovers from the anesthesia, and is conscious merely of an improvement in ability to breathe and in general well-being.

Carl J. Luyties, M. D.: I just wish to say a few words. I heartily commend the paper, but I think we devote too much time to the treatment of disease; we do not pay enough attention to the prevention of these troubles. I think very frequently these enlarged tonsils which are due to constant irritation in the throat from some cause could frequently be prevented. Children, when they are old enough to understand anything, should be instructed to breathe properly. The nasal orifice and throat should be kept in a sanitary condition. Ofttimes there are no obstructions in the nose at all, but by improper breathing and by allowing the natural secretions to accumulate in the nostrils, the child is compelled to be a mouth-breather; and this ultimately develops these enlarged tonsils. There is a large amount of suspended matter in the atmosphere constantly which gives rise to much irritation. I think the children should be instructed to keep their noses clean by the very simple process of ducking the nose in a basin of water without snuffing—simply flushing the nostrils in that way. Many times I have found in my connection with institutions that this has been of great benefit where it has been done systematically.

Another point to which I wish to call attention is the carelessness on the part of physicians in using Politzer's air-bag when the mouth and throat are in a very unsanitary condition. I agree, therefore, with the gentleman who preceded me, that not only should the field be thoroughly clean prior to an operation, but often prior to so simple an operation as the use of the air-bag. I have seen cases which were made very ill on account of carelessness in this particular.

G. Forrest Martin, M. D.: I simply want to emphasize the fact most decidedly that I do not advocate the use of the nail. It is unsanitary and unscientific and unsurgical in every sense of the word,

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but within one month I have seen it advocated in a professional article. I always use an anesthetic, and should refuse to undertake an operation without it.

I cannot agree with the last speaker with regard to obstruction and discharge. I think the habit he refers to is more the result of the obstruction overlooked than the cause.

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EARACHE AND DEAFNESS IN CHILDREN

ROYAL S. COPELAND, M. D.
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Earache is a symptom frequently observed in early life, and one for which there is instant demand for relief. Deafness is a condition more or less fatal to the future usefulness of its victim, and, unfortunately, increasingly prevalent. The subject dealt with by this paper, therefore, must be of interest, not only to every physician, but to every parent.

Statistics may at the same time prove and disprove any proposition. They are not always of burning interest. But here is a statement from a statistical standpoint that should arrest the attention of every practitioner. Ninety per cent of the cases of deafness met with in children are due to post-nasal growths. Furthermore, the majority of cases of recurring earache are, in my opinion, a result of the same cause.

If these statements are based on fact, the practitioner of medicine neglecting to examine the post-nasal space of patients suffering from earache or deafness, overlooks the probable seat of the trouble and renders himself liable to a charge of mal-practice.

Certain infectious diseases, especially if adenoids be present, are prone to attack the ear, and, on departing, to leave behind lasting reminders of their visit. In this connection, scarlet fever and measles are chiefly at fault. Teething, too, is responsible for many attacks of earache, for setting up an inflammation of the middle ear which results in deafness, and sometimes for death itself, from an extension of a suppurative process from the middle ear to the meninges of the brain.

To account for the seriousness of otitic inflammation in early childhood one must not forget the anatomical conditions of that period. The bony plate which in adult life separates the middle ear from the brain has not yet developed, and the only protection to the meninges is a layer of mucous membrane. Naturally, then, earache at this early period portends the possibility of serious results.

Having in mind the dangers of disease of the ear, and knowing the causes responsible for the majority of such cases, our professional duty is as plain as day. The purpose of this paper, then, is to call special attention to the one condition, adenoids.

During the past decade so much has been written and spoken on this subject that it ought to be unnecessary to say any more. It is a sad commentary on medical practice that overlooked adenoids are almost as frequently met with today as they were five years ago.

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The very face of the adenoid victim pictures the disease. One can gaze over the primary department of the public schools, and at a glance select the adenoid patients. In spite of the unmistakeable features of the disease, it is overlooked or unrecognized, time and time again. "The face is long, the point of the nose is pinched, the lower jaw hangs down, the mouth is open, there is often lateral narrowing of the alveolar arch, high palate and prominence of the upper incisor teeth, which tend to approach one another posteriorly; the upper lip projects away from the teeth, the inner canthi of the eye are drawn downwards, the eyebrows raised, while the obliteration of the natural folds of the face gives the patient a stupid, vacant, semi-idiotic expression." Such is the graphic picture of the adenoid victim, given by a recent writer.

Snoring during sleep, flatness of the voice, nasal occlusion, "snuffles," occasional earache, and oft-recurring deafness give certainty to the diagnosis. This is absolutely confirmed by passing the finger back of the soft palate into the naso-pharynx. The post-nasal space is found filled with a mass which feels like angle-worms.

It may not be too much of a digression to mention the nocturnal enuresis, the night-terrors, the failure of mental development, the liability to tubercular infection of the cervical glands, the asthma, convulsions and other conditions which result from untreated adenoids. Certainly enough has been said to direct attention to the chief cause of earache and deafness of children.

In the treatment of these conditions the first indication is the removal of the adenoids. Methods of operation are familiar to all. Every physician has at least an index finger, and if he possess no other means of operation he has at his command a method of removal, which, in many cases, is quite as satisfactory as Gottstein's curette, or Schutz's adenotome. Thorough removal is the rule, and free hemorrhage from the throat and nares is the test of thoroughness.

The evolutionist claims that the removal of adenoids renders the race more liable to the condition, and predicts a marked increase in deafness on this account. This theory, I suppose, is based on the belief that the removal of the adenoid improves the health and well-being of the individual and leaves him more likely to propagate the race. He survives with the fittest. Instead of failing in health and dying off, thus freeing the human family from the taint of adenoids, the surgical removal of the growth saves the individual, but inflicts the condition upon the offspring.

Personally, I am not prepared to accept this theory. However, in some families, there does appear to be an underlying tendency to hypertrophy to demonstrate the superiority of this system of practice. The

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remedies which cover the underlying diathesis will correct the tendency to the development of adenoids.

The special topic given me does not permit long discussion of these remedies, but I desire at least to call attention to four, viz.: *Calcarea phosphorica, sanguinaria nitrate, fluoric acid* and *aesculus hippocastanum.* So far as I know, professional attention as to the possible value in this condition, has never been called to the last two. They are worthy of study, and will be found useful in this connection.

For the earache itself it is unnecessary to outline any system of treatment. Every physician has his favorite method of cure. Removal of the adenoids, if done before the deafness has long persisted, will remove the obstruction from the eustachian orifice, and of itself be quite sufficient, in most cases, to restore the hearing.

The use of the air-bag, and Siegel's speculum, or some form of vibratory massage, will complete the cure.

Your essayist is quite content if he has said enough to set some mind to thinking about an unrelieved case of earache and deafness in a little child, and to wondering if an adenoid throat has been overlooked. He fully realizes the frailties of human nature, and is ready to accept criticism for some of his mistakes, if perchance he may be permitted to scold a little about the mistakes of his fellow-practitioners.

In conclusion, therefore, let me beg of you to examine the pharyngeal wall of every patient suffering from earache or deafness.

Discussion:

T. M. Patterson, M. D.: The fault with many general practitioners, and not a few specialists, is, that they do not think of adenoids unless they have a typical case, "with the long face, the point of the nose pinched, the mouth open, lateral narrowing of the alveolar arch, high palate, etc.," as outlined in Dr. Copeland's most excellent paper.

In my experience many of the cases with ear complications show no outward signs of adenoids, and a great number of them are not even mouth-breathers, except when suffering from severe attacks of coryza. Still the adenoids surround the pharyngeal opening of the eustachian tube and by its partial or complete stoppage interfere with proper ventilation and drainage of the middle ear. Therefore, in all cases of recurring attacks of inflammation of the middle ear or of deafness in children, I make it a rule to explore the post-nasal space with my finger, and can not now recall a single instance wherein I have failed to find adenoids.

It seems inexcusable to overlook a case of this kind where the facial expression is characteristic, but as Dr. Copeland says, it is done, and I might add that it is more neglected by members of our school than by members of the dominant school of medicine. The reason for this may be that we depend too much on the indicated remedy for the relief of the symptoms.

After numerous trials I have never seen any permanent results

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from any form of internal medication until after thorough removal of this tonsil; then, Calcarea carb. or Calcarea phos. are with me most frequently indicated. Sanguinaria nit. has seldom been called for, nor have I had any experience in this condition with Aesculus hippocastanum, or Fluoric acid. I cannot, however, agree with the essayist when he says "that the index finger is a method of removal which in many cases is quite as satisfactory as Gottstein's curette or Schutz's adenotome," nor when he says "that free hemorrhage from the throat and nares is the test of thorough removal."

I am satisfied that I get better results from the use of the curette and in many cases, the adenoids forceps. To my mind the only test for thorough removal is, to feel in the vault of the pharynx and find that no traces of this enlarged tonsil remain.

To do this operation thoroughly, in most children, it seems to me that a general anaesthetic is necessary. Dr. Copeland has certainly not overdrawn the evil consequences of neglected adenoids, and what he says in this connection I must heartily endorse.

E. R. Eggleston, M. D.: Any attempt to criticise this most excellent paper would prove harmless; to attempt to add to or subtract from its fulness upon the special topic with which it deals, would prove useless. To say anything upon the subject, therefore, there remains only the possibility of rounding out or filling in ellipses here and there, or to present such ideas as different experiences and studies may suggest.

The first point to refer to is that of *predisposition*. Even slight affections, catarrhal chiefly, are prone to leave behind them residues, exudate or tissue change, that are easily revived. These form a basis of many ear troubles. But if at the same time a diathesis is present, as the adenoid, already described in the paper, such results are almost invariable. Predisposition is especially effective in neuropathic conditions, and of these neuritis is most common.

Next, the *diatheses,* of which the strumous is the most prolific in ear affections. Notice again what has been said of adenoids. Its intimate relations with nutrition, with neighboring lymphatic mechanisms, and with the like functions of all other organs of special sense, are familiar to all and therefore only require to be mentioned. These subjects are of course of very great importance and richly repay such careful study as our essayist has given to them.

But it is with neuropathic conditions, which have not been so generally investigated, and are at least of equal importance, that I am at present chiefly interested. It may be set down that some part or the whole of the auditory mechanism may be affected by reason of disease in each of the other special mechanisms, eye, nose, mouth, throat and vocal apparatus, through nerve connections, as well as through more general conditions, constitutional, systematic or specific.

It may be of interest to very briefly indicate some of the most prominent of these connections.

The first cranial pair, the olfactory, after their origin in the temporal lobes, are at once associated with the optic thalami; thus intimately connecting them with the eye and ear.

Again, Ramsey says: "Oscillatory movements of the eyes may

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accompany vertigo dependent upon disease of the acoustic apparatus;" showing association between optic and auditory apparatus, probably through thalami or post-cerebral and temporal centers.

Again, the association of the seventh and eighth pairs, facial and auditory, through filaments forming the chorda tympani, associate the sense of hearing with that of taste; also accomplished through connection with the glosso-pharyngeal, or ninth pair, which also supply soft palate, pharynx, eustachian tubes and tympani, and therefore the middle ear. In Bell's paralysis of the seventh, facial, hearing may be modified by implication of filaments to the stapedius muscles.

The fifth pair, trigeminus, are associated in a marked way with deglutition, mastication and hearing. Nerves of the internal and external ear are closely linked with those supplying forehead, temple, face, nose, teeth and tongue.

The very wide distribution of this nerve, its influence among diseases of all the organs of special sense, makes it deserving of more particular notice, for, you will understand, generalizing is not a very valuable means of reaching definite conclusions. Purely irritative conditions, with spasm and therefore pain as a typical result, may arise in apoplexy, cerebral softening, meningeal exudation, lesions of pons and medulla, hysteria, epilepsy, tetanus hydrophobia, tumors, trauma, and various external causes. Either may or may not affect the hearing, but all enter into questions of differentiation, to be ruled out or in as the case may require; and a number of them are of especial importance in cases of children.

Central causes, such as are more likely to cause general and permanent results, comprise apoplectic clots, degenerative lesions, localized diseases and deposits, and lesions of the medulla. It is of diagnostic importance that, as a rule, the inferior maxillary branch of the fifth only is involved in central lesions.

External causes include traumatism, exposure to cold and heat, surgical procedures, caries of bony canals, suppuration of soft tissues, and local growths and exudations. These usually affect single branches.

There is, then, through this nerve, very close association in the nerve supplies of the ear, eye, nose and throat, and disease of one may induce disease of the other for the same reason; and what is true of this nerve, with its wide distribution, is true of others with their narrower distribution.

We need not go so far, then, to conclude that ear-pain and deafness, whatever the age of the subject, may point not alone to auditory disease, but frequently to disease of other organs or nerves of special sense, as well as to adenoids and other more general diseases It may be that the percentage margin allowed us by the essayist, ten per cent, is sufficient to cover those cases and those more general; but it appears to be rather small.

There are, then, the olfactory, optic, trigeminus, facial, glosso-pharyngeal, and auditory nerves, and others more remote, as well as cerebral and bulbar centers, all bound more or less closely together, and all susceptible of secondary irritation. The conviction of a general practitioner is that in consequence of an original pathological process, located in whatever field it may be, a new one has been set up,

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either along the course of continuous nerve tracts or those in relation with it. In other words, disseminated or localized neuritis accounts, in large numbers of cases, for the whole complex of symptoms in either case. Thus ear-pain and deafness not accounted for along lines assumed in the paper, and impossible otherwise to account for, may be traced to causes and their true pathology established.

And finally, I would bespeak a safeguard against the mischievous error, too commonly taught, that abnormal conditions of one special nerve system may be reproduced in kind in another special system of unlike kind through reflex channels. Such conclusions are commonly mistakes. Reflex symptoms are confined to their own circuits; and circuits to their own systems; and systems to their own fields of distribution and function. They are not to be speciously flitted over tissues and spaces and mechanical contrivances such as nature has set up for their limitation as well as for their accommodation.

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PATHOGENIC TREATMENT OF PATHOLOGIC CONDITIONS

B. F. Bailey, M. D.
LINCOLN

It has been said, "God never meant that in this fair but treacherous world in which he has placed us we should earn our salvation without steadfast labor."

It sometimes seems to me that we are too apt to attempt to assimilate the labors of others and reap therefrom benefits, without an effort to add one iota to them.

The assembly of Rhode Island replied to the authorities of Massachusetts when that colony asked for aid in the suppression of the Quaker, "Let us not be compelled to exercise any civil power over men's consciences." It behooves us to use the reasoning power that God has given us, looking to the improvement of the methods of our progression that we may fulfill that fundamental law of life, that only by labor can we accumulate blessings, and that at the same time we form firm convictions of our own in accordance with the study of cause and effect, we also look to our fellows and receive from them their convictions, weighing them in conjunction with our own, and giving to their findings the respectful consideration that is due any honest investigator, and never cavil or attempt to control other men's consciences or judgment any more in the twentieth century than would the assembly of Rhode Island in the seventeenth century. With this foundation thought in mind I do not hesitate to advance some thoughts concerning the general treatment of the diseases of children as especially related to the homœopathic materia medica. Ever since the days when I was grounded in my materia medica by the teachings of that thorough teacher and notable character, Dr. Farrington, I have recognized more and more that at least so far as my work has been concerned it has been necessary for me to read between the lines in the use of our symptomatology. It is startling to the student to see how many common conditions, as read by the superficial observer, are covered by many different remedies. This statement is questioned! He who questions it may not be a superficial reader. To him this statement means nothing. Again this statement is questioned! The questioner is perchance one of our profession, a scoffer at our symptomatology that goes hither and thither searching the by-ways for easy roads to treatment. Such a one is not a judge. There are, however, some candid minds who will recognize the truth of this assumption. The strength of the materia medica of Hahnemann is, to my mind, that it is

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pathogenic in its character, and if it is properly used it strikes at the very origin of causes, and the treatment being pathogenic in character effects must vanish, whereas treatment that strikes alone at effects and does not remove the cause but temporarily relieves. For instance, the opiate relieves pain, but it does not remove the cause, but rather by its disorganizing effect in temporarily paralyzing reflexes, is followed by increased irritability of reflexes and tends to increase the cause rather than in any sense to remove it. The same is true of the bromides used in massive doses. It would seem an axiomatic fact that the human system has natural resistance to disease, and that if it were not for this we would be continually overcome by exposure to disease causes, for it is as axiomatic a fact that every disease must have a cause as that the system resists the causes.

This immunity may, according to modern theories, be natural or acquired. When disease obtains, the cause of disease has been stronger than either the natural or acquired immunity. That a person in perfect physical strength is in a condition to best resist disease is unquestionable. That if, for any reason, the physical powers are weakened, as by the old so-called scrofulous diathesis, or, as we now know it, mal-nutrition, the power of resistance to disease is unquestionably weakened. It is altogether probable that acquired immunity is simply the strengthening of natural immunity, probably through bringing into more active work the natural powers by means of so-called artificial stimulation. This may be through the methods of modern science, or through the natural protection from second attacks that are given to us by primary attacks of certain diseases.

MacFarland writes: "One of the most remarkable facts observed in comparative pathology and physiology is the resistance which certain animals and classes of animals, not differing very much from other animals, but often differing very widely among themselves, show to the invasion of their bodies by the germs of disease."

Man suffers from typhoid fever, cholera and other infectious diseases which do not affect the domestic animals. Pleuro-pneumonia of cattle does not affect man. The cat, dog and horse resist tuberculosis, which so readily attacks the cow and the guinea-pig. Yellow-fever rarely attacks animals. So far as science and the study of comparative anatomy and physiology have taught us, there is no reason for this difference in the coarser structures or in environment. It is rational to suppose that it must rest on the chemical or catalytic behavior of the constituents of animals in their more intricate processes.

We know the common rat will succumb to anthrax which the white rat will resist. We know that from the mouse that has had tetanus and recovered, a few drops of blood may be injected into another mouse and

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render that mouse immune from anthrax. That immunity exists, either natural or acquired, in man and certain animals, as against certain diseases, may be assumed.

That this immunity rests upon certain conditions which are so insecure as to be almost startling, is equally true. That man is exposed to tuberculosis almost every day of his life is without question. That probably 50 per cent of the careful autopsies show past lesions from tuberculosis, we know. That of the other 50 per cent a large number have been equally exposed, but were immune, hence have not contracted the disease, and that those that have recovered have, a large percentage of them, been semi-immunes, and hence the vital forces have been able to combat and conquer in the struggle with this disease, cannot be doubted.

Roger found that the white rat that is immune to anthrax before being exhausted, upon being compelled to turn a revolving wheel contracted anthrax. Ergo, the protective power may be held in abeyance if from exhaustion the system of the animal falls below par.

Pasteur demonstrated that chickens ordinarily immune to anthrax would contract it if the temperature was first reduced by plunging them into a cold bath, and yet the temperature alone could not furnish the immunity, as the sparrow with equally high temperature readily acquires anthrax.

Leo found that rabbits fed with phloridzin had their immunity to anthrax destroyed.

Platina found that immune dogs, frogs and pigeons acquired anthrax if subjected to feeding on curare, chloral or alcohol. It is of course true that so remarkable a series of experiments as have been carried on in regard to the subject of immunity have developed numerous theories as to its cause. They are intensely interesting, but as Ernst says, "Alas, we have explanations, but they are as intricate as the phenomena, and although each may possess its grain of truth, not one will satisfy the demands of the thoughtful student."

We have the exhaustion theory, the retention theory, the theory of phagocytosis, the humoral theory, and the theory of defensive proteids. We have only time to mention this and to draw from certain of them material for thought. It is altogether probable that the investigations of Metchnikoff are as reliable and furnish to us as real information as that of any investigator. He gave us results in 1884 that confirmed the suspicions of Virchow in 1840 and Koch in 1878. He found that leucocytes really did destroy bacteria. He demonstrated "that the more immune the animals the greater the affinity of the leucocytes for the bacteria." He demonstrated that the organisms destroyed by leucocytes are collected in the spleen and lymphatic glands.

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Bardach found that extirpation of the spleen diminished immunity to infectious diseases.

Ruffler found proof of the most distinct difference in the phagocytic selection of organisms, as, for instance, they will leave the streptococci in diphtheria for the Klebs-Loeffler bacilli, which would certainly furnish apparent explanation of the fact that in diphtheria, if the system resists death for a long time, the secondary lesions are not usually those of the Klebs-Loeffler bacilli, but of the streptococci. It has also been demonstrated that the trend of the system has in time also destroyed the streptococci, hence there is an ever-present phalanx for defense, it being only a question, probably, of the violence of the attack of the enemy as compared to the more or less perfect strength of the defending forces.

Wyssokowitch found that saprophytic and pathogenic organisms were inclined to collect in greatest numbers in the liver, spleen and bone-marrow, and were destroyed there, the first in a few hours, the second in twenty-eight to forty-eight hours. It is in these localities that we have reason to believe that phagocytosis is the most active, the phagocytosis theory having furnished in these investigations a reasonable basis for belief, but as yet it has been impossible to give an easy and acceptable theory for acquired immunity. I will not go over the attempted explanations which seem to me, as well as to numerous writers on the subject, to be somewhat ultra-rational.

The antitoxin theory must be mentioned on account of my desire to draw further conclusions. The amount of antitoxin necessary in certain experiments to preserve mice, Ernst says, is so infinitely small that it is difficult to give the exact notion of it. Serum activity of one-millionth and more has been obtained.

Metchnikoff found that in his experiments upon animals serum did not act by neutralizing hurtful action, but by increasing the activity of the means of defense.

Metchnikoff formulates the theory that preventive serum acts by stimulating phagocytes, making them less sensible to the toxins, and exciting them in their struggle against the bacteria. We have now the right to infer that certain conditions of immunity do exist, that these conditions of immunity, though differing in different animals and in man, are greatest in a perfectly normal condition of the animal. This of natural immunity, and in many cases experiment has demonstrated that acquired immunity may be obtained by the experimental change or stimulation of certain life-processes by means at our command, and, further, that natural immunity certainly, and acquired immunity possibly, may be destroyed by certain methods which depress certain organisms to the condition below par and make these conditions such as we often find in life, as, for instance, exhaustion, or overwork, as in the case

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of the white rat exhausted by being compelled to turn the wheel; exposure, as of the pigeon in the cold bath, or over-medication or stimulation, as in the animals fed upon curare, chloral and alcohol.

Woodhead has demonstrated that quinine, which it is known in large doses increases the destruction of leucocytes, renders rabbits and some other animals more susceptible to anthrax. It having been proven that the animal world, including man, with perfect bodies, is strong in its defense against its enemies, it is a reasonable assumption that the pathogenic cause of disease may be anything which allows the system to be more or less changed from a normal and perfect condition, thus rendering it susceptible to enemies from within and without. Assuming this to be a fact, what may be considered pathogenic treatment for pathologic conditions? It is not that I would assume to outline for each pathologic condition a pathogenic treatment, but that I would bring before this section of our Institute, at this critical period in our history, when under improved conditions we are about to make new provings, an argument looking to the more scientific investigation of the subject which may lead to the positive proof that the explanation of every great discovery in experimental therapeutics of the last few years is based upon the theory of Hahnemann, who gave to the world far more than he knew.

No one has been able to explain in a satisfactory way the action of homœopathic remedies, and I believe it has been left for some of our compeers of another school to demonstrate the *modus operandi* of homœopathic therapeutics. What more beautiful illustration of the action of our theory than this very quinine, which furnished perhaps the first of the remedies to interest Hahnemann in *similia,* and that now is shown by Woodhead not only to destroy leucocytes, but also to destroy immunity, and yet we know that in minute doses it is a stimulant to immunity and to even the growth and activity of leucocytes. We know that in malaria, if administered in massive doses, it is purely germicidal, while we have seen that *natrum muriaticum, natrum sulph.* and other remedies in minute doses cure cases of malaria in which even the germicidal properties of quinine had failed to be effectual.

There is scarcely a material of food or medicine that does not carry with it some of the constituents of the human body. That from our articles of food we derive the renewal of our bodies, we know. That it is impossible to exist without this continual renewal is certain. That times come when the human body fails to assimilate the necessary quantities of certain constituents through continually taking them into the system, we well know. That it is impossible to supply this need by additional food or isolated bodily elements, and that this attempted correction in theory has usually been found faulty in practice, is a matter of general recognition. That in giving *ferrum phos., kali phos. and calc. phos:* we

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do not expect to supply a lack, but correct a faulty assimilation, goes almost without saying. That it is impossible for us, in the present state of our knowledge, to tell exactly upon what element contained in most of our remedies the curative action rests, we must admit; but that in many cases it may rest upon constituents of the salts of the body contained in a drug material may be true, as in the assumption of Schussler.

In 1832 we had the first suggestion of Schussler's theory, but it was he himself that in March 1873, published an article on "Shortened Homœopathic Therapeutics," and in this country it was taken up and followed quite enthusiastically by no less a man than Dr. Constantine Hering.

Hahnemann and his followers have developed a field of materia medica greater than any man can master, and more perfect than any man had ever before introduced to the world. It is true of this materia medica, and I have heard it said by the late Dr. Farrington that the more thoroughly a man studies this materia medica and the more perfectly he knows his remedies, the fewer of them he finds himself called upon to use. I think this will be admitted by the thoughtful practitioner of to-day. If this is true, may it not be possible for us to find, by the careful study and proving of Schussler's remedies, that we may much more modify our system of homœopathic therapeutics, and if it is true that there is something in the theory of Schussler, and I believe it has been demonstrated that his theory has much in common with Hahnemann's *similia*—though most of the remedies have not been proven—may it not be equally true that we shall find in our study of the action of other constituents of the body, either isolated or combined, an equally marvelous action according to the law of *similia,* and if it is true, is it not worse than ignorance, is it not even a product of bigotry, for us as a school to use so commonly the Schussler remedies, which would perchance act much more satisfactorily if given hypodermically, and at the same time condemn and refuse to investigate the possibility that other elements, either isolated or combined, may have a like action, and thus add to the truly vitalized homœpathic materia medica.

This section deals with the diseases of children. "The child is father to the man." The physical condition of the child lays the foundation, not only for the diseases of childhood, but for the diseases of manhood, and if the foundation is weakened the superstructure can never be strong and trustworthy. It is startling that in nearly all the diseases of childhood and nearly all pathologic conditions we find most used and recommended in our school either the Schussler remedies or their allies in materia medica. It is a lamentable fact that in the study of the child in its ordinary environment, in its inherited condition, and with a view

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to the prevention of disease, we find here conditions of malnutrition which are continually yielding to disease.

Burnett tells us of bacillinum, and he who uses it at the same time often condemns antitoxin, the germ-theory, the theory of immunity, *et cetera,* whereas we must know as honest men that the action of bacillinum, in the doses in which we use it, must be as mysterious in its action as is serum-therapy. It cannot be an antidote. It is simply a message to the general of the host to put his phagocytic army into the field with armor burnished and with the strength that can only be born of previous preparation.

Notwithstanding the argument of some users of antitoxin that it is the large doses which necessarily cure, I do not believe it is demonstrated that such is the case, and I feel positive that in the Schussler remedies, with such other additions thereto from different bodily constituents, isolated or combined, as experiment may prove to be desirably used in accordance with *similia,* said remedies having been proven with scientific thoroughness and used not only for the cure of disease but for the prevention of disease, we shall find the future pathogenic treatment of pathologic conditions, we shall be able to prove, and stand steadfastly on that proof, that when even in the coarser experiments of these early days in serum-therapy dilutions of even one-millionths are used, greater dilutions even yet may be used, and hence our doses are no more wonderful in their theory of action than are the doses of the serum-therapeutists, and the doses of the serum-therapeutists and their results are no more wonderful than are our doses and our results.

You say this is but a theory. September, 1891, in the *Medical and Surgical Reporter,* of Omaha, I published a short article on a new theory in regard to hay-fever, in which I expressed my convictions that hay-fever was due to lithemic conditions. This was but a theory, but it was the first time it had been advanced in medical literature. The next one to take it up was Tyrrel, of Toronto, in 1892, and then Bishop, of Chicago, in 1893, until to-day the theory has become a certainty, and is a recognized entity in medical diagnosis and treatment.

Pasteur, who loved France and humanity better than self, and who was said never to have spoken for the first time with a student without saying to him, "Work perseveringly; work can be made into a pleasure, and alone is profitable to man, to his city, to his country," and who believed heartily in the enthusiasm which was the outgrowth of the *Oeos,* or inward God of the Greeks—this great man, who by his life-work reduced the mortality in surgical cases from 50 in 100 to 5 in 100, and in lying-in hospitals from 200 in 1,000 to 3, and finally 2 in 1,000, said: "Without theory, practice is but routine, born of habit. Theory alone can bring forth and develop the spirit of invention. It is to you espe-

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cially that it will belong, not to share the opinion of those narrow minds who disdain everything in science which has not an immediate application."

You know Franklin's charming saying? He was witnessing the first demonstration of a purely scientific discovery, and people around him said: "What is the use of it?" Franklin answered them, "What is the use of a new-born child? And yet, perhaps, at that tender age, germs already existed in you of the talents which distinguished you! In your baby boys, fragile beings as they are, there are incipient magistrates, scientists, heroes as valiant as those who are now covering themselves with glory under the walls of Sebastopol. And thus, gentlemen, a theoretical discovery has but the merit of its existence; it awakens hope, and that is all. But let it be cultivated, let it grow, and you will see what it will become."

And so Franklin brought glory to America, Pasteur glory to France, and the broad spirit of tolerant investigation may bring lasting fame to Hahnemann and his followers.

DISCUSSION:

J. P. SUTHERLAND, M. D.: I feel at a distinct loss as to what to say in the discussion of so excellent a paper. The fact is, when I accepted our chairman's invitation to discuss it, I was attracted by the title itself: "Pathogenic Treatment of Pathologic Conditions." I did not know what Dr. Bailey would have to say on the subject, but I knew it would be something interesting, and I thought perhaps there might be something to say in the way of discussion, but he has treated the subject so thoroughly, and stated his facts in so clear and convincing a way that I really see nothing to discuss.

In regard to immunity, I think we agree with him very thoroughly indeed. In regard to the title, however, there is a word to be said. We treat, of course, "pathologic states," that is, conditions of ill-health; physiologic conditions never come before us for treatment. Now, I could not help wondering when I first heard the title just what Dr. Bailey would make of the first part of it, or "pathogenic treatment." My own mind ran along some such channel as this—a "pathogenic treatment" is a sick-making treatment; a treatment characterized by the use of drugs in large doses. For instance, my idea of "pathogenic treatment" would be the use of irritants, vesicants, cathartics, hypnotics, or the use of blood-letting, or something of the sort, to produce a certain condition that in some peculiar way might counteract a diseased condition and assist the patient to a condition of health. In thinking of our own method of treatment, it seems to me we must look upon it as "non-pathogenic"; that is, we do not use drugs in doses large enough to produce a condition of ill-health; that is, a sick condition. Apropos of this, you recall, doubtless, Hahnemann's explanation of the curative action of drugs. If we follow Hahnemann in his explanation, then we must consider that our method of treating is a pathogenic treatment. Hahnemann claimed that nature reacts against an artificially induced

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disease—that is, a drug-disease—more quickly, more certainly and more effectively than against a natural disease; and that drugs are stronger than the miasms or causes of natural diseases. Therefore, the drug, in accordance with the law of similars, after its exhibition supplants the natural disease, and nature, being unable to throw off the natural disease, and having greater power to cope with the drug-disease, is able to throw off the latter, and thus bring about the cure. If we accept this explanation, then we must look upon homœopathic treatment as "pathogenic treatment."

There is another explanation, one that has been hinted at by Dr. Bailey in his paper; and that is the effect of drug action upon leucocytes. I like to study them, and I wish I knew more about them. I look upon them as the most interesting cells found in the animal body. They are less differentiated than other cells in the body, and they are able to perform all sorts of functions. Among these is that known as phagocytic; that is, the power of destroying things. They destroy germs, or micro-organisms, which are inimical to health, but they act in other ways. They do not always kill micro-organisms. We know they are sometimes killed by micro-organisms. One of the best instances of this is the battle that is waged between the gonococcus and the leucocyte; and here we have a beautiful example of the leucocyte giving up its life for the salvation of the health of the individual. In this case the leucocyte absorbs or ingests the gonococcus, which lives upon the cytoplasm of the leucocyte. But the leucocyte has a migratory propensity, and it seeks the surface of the body; that is, the mucous membrane, and is thrown off, carrying the micro-organism with it. But the leucocyte gives up its life. This is not strictly a phagocytic action, but it is due to the activity of the leucocyte. Leucocytes also secrete something, a sort of anti-toxine. It neutralizes the toxine or the miasm which produces the disease. They act in various ways, and their action is always to me an interesting study.

But as to non-pathogenic treatment. The dietetic treatment of malnutrition, and dyspepsia, the use of water in lithæmia, the use of inspissated gall in constipation, the use of anti-toxine—things of that sort—in addition to the homœopathic remedy, exhibited as it is usually exhibited, must be looked upon as non-pathogenic treatment. And yet our treatment is based upon a knowledge of drug pathogensy, and this, I take it, is the object of the paper. And right here I would disagree with the essayist, Dr. Bailey. It is the only point in his paper—a most excellent one—on which I see any chance for disagreement; and this is his commendation of the Shussler, or tissue-remedies. It seems to me that this is a point that might be discussed—the only point, as I say. I have always been radically opposed to the use of the so-called tissue-remedies upon the tissue basis. They are used in accordance with some physiologic theory, and not in accordance with the rule formulated by Hahnemann; and the thing for us to do is to prove these remedies. As Dr. Bailey has said, most of them have not been proven.

B. F. Bailey, M. D.: I have only one thing to say, and that is this: I did not take this subject. It was given to me by a friend. I do not know what he meant. What I meant was this: to give pathogenic treatment and strike out the cause of the disease. I wonder if my friend that gave it to me meant the same thing!

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THE PREVALENCE OF INFANTILE MUSCULAR ATROPHY, ITS ETIOLOGY AND TREATMENT, WITH REPORT OF CASES

J. G. CHADWICK, M. D.
BUFFALO

Every physician here has seen at least one case of this dread malady, and no doubt there are many of you older men who have seen several cases. How prevalent this disorder has become during the last few years many of you know; and if this be true, and we have every reason to believe that it is, then we should make a careful investigation in every case that we are called upon to treat, in order to find its true cause.

It has been my fortune or misfortune to have had four of these cases under treatment the past two years; three of them made excellent recoveries, the fourth succumbed after an illness of many weeks. All of these were typical cases of simple atrophy, of high-grade type.

Infantile muscular atrophy is essentially a disease of early childhood, the large percentage of cases occurring before the end of the first year. It is a familiar occurrence in hand-fed babies, and is now becoming one of the most frequent causes of death in early infancy. It is a condition in which extreme atrophy of all the muscular tissues takes place without any demonstrable disease of any of the organs. It is apparently due to a vice of absorption, although this has by no means been clearly proven.

The etiological factors present in this disease are many, although the primary cause is often unknown. It is most frequently encountered among children of the poorer classes. It usually occurs during the first twelve months, but is also often met with during the second year. It is a condition of wasting and emaciation presenting a type of symptoms usually found in cases of inanition or starvation. It may arise even in breast-fed infants, as well as those artificially fed, being in either case due to insufficient nourishment.

That brings us to a consideration of infant feeding, and this can be insufficient in one of two ways; first, when it is supplied in amount too limited to meet the demands of the system, and second, when it contains a minimum of the elements essential to nutrition, or presents them in a form poorly adapted to the very feeble digestive powers of infant life. Starr, in the "American Text-book of Pediatrics," says that "an infant may waste when nursing either from a breast that yields too little good milk, or from one that secretes abundantly, a poor, watery fluid that is, in consequence, unfit for nourishment."

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How often are we called to see mothers who are anxious to nurse their children, but where lactation is a failure after the 3rd or 4th month? And it is for that reason that the question of ability to nurse should be settled as soon as possible after the birth of the child. This is very often the beginning of wasting in the child, and the lives of children should not be jeopardized by the useless efforts of a conscientious mother to do what she is physically unable to do. The physician should be familiar with the symptoms of inadequate nurse, in order that valuable time may not be wasted. And if artificial feeding is to be employed, the difficulties in the way are much less when it is begun early than after the digestion has become deranged by several weeks of poor nursing.

When a child is not obtaining sufficient nourishment one of the first symptoms that will be noticed is a rise of temperature; ranging from 99 degrees to 101 degrees F. Second, there will not be any appreciable gain in weight. This will at once be noticed, if the child has been under observation for two or three weeks, and has been weighed twice weekly. Normally a child should not gain rapidly, but should always gain steadily, unless obvious signs of disease are present. Third, the sleep is irregular and disturbed. If, after being nursed, a child wakes habitually fifteen to twenty minutes after being put down, and rarely has a long sleep except from exhaustion, the probabilities are that the food is insufficient in quantity or poor in quality. Fourth, there is usually much fretfulness or crying. Fifth, the stools are dry and hard and of unnatural color. Sixth, the child will nurse for a long time, and then not be satisfied. Seventh, as a consequence of this lack of nourishment, we have the associated symptoms of wasting.

The above symptoms are certainly characteristic enough to enable one to determine that the child is not thriving. The proper course now to pursue is to have a thorough examination made of the breast-milk, and learn in what particular the milk is abnormal; whether it is simply the quantity that is at fault, or the quality, or both. This examination does not always solve the problem, but it lends great assistance in the majority of cases; and if this is carefully and conscientiously carried out by the physician I believe there will be fewer cases of marasmus. The physician can at least determine the cause of the malnutrition, and will be in time to prescribe the appropriate treatment.

According to Holt, of New York, the milk-examination will disclose one of four conditions, namely, first, an over-rich milk, with the quantity usually abundant. Second, milk poor in quality, and scanty. Third, where the quantity is diminished, but the quality normal. Fourth, the quantity abundant, the quality very poor.

We know that we usually find an over-rich milk in women who are apparently in good health, having large, well-developed breasts which

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are tense and hard at every nursing-period. Then again, we find milk tnat is poor in quality and scanty, in a delicate or anemic mother, who has had a difficult or complicated labor, and having an anxious, careworn expression.

The question of inadequate nurse and examination of the breast-milk might seem unnecessary to many, and not bearing directly on the topic assigned me, but I am convinced that the paramount etiological factor in this trouble is that the above symptoms are not recognized in time, and the examination of the milk is neglected. If the symptoms that follow from insufficient nourishment could be detected early, the proper treatment could be substituted in time to save the child's digestive powers, but instead, these cases go on until the child is from four to eight months old, and then weaning is advised. If the examination of the milk had been made early, something could have been done to improve the quality, or judiciously increase the quantity of the mother's milk, so as to make it proper for the child. For example, if her milk be excessively rich, we are able in most cases to modify it by a reduction in the diet, and allowing an increase in the amount of daily exercise. Poor milk is low in its percentage of fat, and scanty, while the amount of proteids present may be either high or low.

With the artificially fed babe the condition is usually opposite, for here the trouble is rarely with the quantity, as it is with the quality. How often we are called to see babies whom we find are being fed on undiluted cow's-milk, or oat-meal food, entirely; or, as I have frequently seen, the milk thickened with ordinary table-food, such as meat, vegetables and bread. Such substitutes as these are fed to babes a few weeks old, and in many instances it is a very hard matter to convince the mother that the reason of the child's sickness is in the quality of the food. We will all admit that the above articles are nutritious, but the digestive apparatus of a month's or six months' babe is not sufficiently developed to prepare such materials for absorption. Such aliment, also, when remaining undigested in the stomach and intestines, undergoes fermentation, with the conseqeunt formation of irritating products, which in like manner produce vomiting or diarrhea, and these conditions surely lower the child's vital powers and hasten the atrophic condition.

The disease may sometimes be traced directly to the apparatus used in the feeding; there is so often a want of cleanliness on the part of the mother; or the bottle and rubber-tube or nipple may be so complicated as to be very hard to clean. I recollect seeing a nursing-bottle recently that was so complicated in its make-up that it would seem impossible to sterilize it. When a bottle of this sort is used, even when it has been subjected to the most careful and frequent cleansing, a sour odor can be detected, and often numerous small curds found present.

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Wasting is less serious in breast-fed infants; but occurs quite frequently. There are many additional causal factors producing it in those suckled at the breast. For instance, an infant may be given to a wet-nurse whose own baby is much older than the child she is to nurse. In this case the milk is too strong, for it is an established fact that as lactation advances, human milk becomes richer in curd and cream, and the nursling being unable to assimilate it, ceases to thrive and consequently suffers from indigestion and diarrhea. Dietetic and emotional disturbances often influence the character of human milk, and by so doing weaken the quality of milk and make it unfit for food. Some children will waste because of an impairment of it's own digestive organs; for an example, an attack of catarrh may impair the digestion.

The pathological conditions which are found in cases of infantile atrophy are exceedingly unsatisfactory, and have not given us much information concerning the disease. There is an atrophic condition of the muscles. Nothing abnormal is found in the various organs which can be especially attributed to this disease. It is supposed by some pathologists that the lymph-glands are enlarged; but this enlargement does not seem to be a prominent feature of the disease. No pathological condition of the mesenteric lymph-glands has been found, and the atrophy of the mesentery around them is so great that their increase in size may be seeming, rather than real. In the intestines, (although in some cases there is considerable atrophy of the mucous membrane and sub-mucous tissue) no characteristic lesion has been found present.

In making a study of the symptoms, we may, for convenience, divide them into two groups, or classes; for the symptoms and clinical phenomena will differ materially, on the one hand, as to whether the food is suitable but not sufficient in quantity, or, whether the condition has been brought about by unsuitable food entirely.

The symptoms of this first group are almost identical with those found in cases of starvation; and are most frequently encountered in children who have been nursed at the breast of over-worked mothers, in which the milk-supply is very scanty and poor in quality. First, there is gradual loss of plumpness, the muscles become flaccid, and there seems to be an arrest of growth. The face is white, the lips thin and pale, the skin harsh and dry, or too moist, and the anterior fontanel will be found depressed. The temper is irritable and sleep restless and disturbed; or, the child is abnormally quiet, dozing constantly and sucking his fingers until they become raw. When nursed, the child seizes the nipple ravenously; then, if there be little milk, he quickly drops it, to cry passionately, as if disappointed at not being able to satisfy his hunger; but if the milk be abundant, though thin, he will lay a long time quietly at the breast and often fall asleep with the nipple in his

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mouth. The bowels are inclined to be constipated, the stools being scanty, hard and dry. Physical signs connected with the chest and abdomen are not important, and there is no indication of disease in any of the organs of the body.

The symptoms of the next group are far more serious than the preceding one, for in this we have the features of wasting in association with those of irritation of the alimentary tract. The infants presentng this train of symptoms are usually hand-fed.

Emaciation progresses with great rapidity, and its extent is dependent upon the original strength of the child's constitution, the age at which artificial feeding was begun, and the sort of food employed. It is often noticeable that an infant several months old weighs less and appears smaller than at birth, and this happens even after a large quantity of food, such as it is, has been consumed. It does not seem possible that a child with such pronounced wasting could have such a voracious appetite, and some clinicians have offered this explanation for its occurrence, claiming *that the unsuitable food, by irritating the mucous membrane of the stomach, creates a fictitious appetite.* Soon the face becomes pinched and the eyes sunken; the lips are pale, and when moved display a deep furrow about the angles of the mouth; the facial expression is uneasy and languid, and the anterior fontanel is found to be much depressed. The skin generally dry and rough, and hangs in loose folds over the bones, and may be mottled with an eruption similar to that of urticaria. The extremities are cold and the hands claw-like. The tongue is heavily furred, and with the mucous membrane of the mouth may be the seat of aphthous ulceration or thrush deposit. As mentioned above, the appetite is ravenous, and its frequent cries of hunger are only temporarily silenced by food; thirst is increased; colic is usually present, the bowels are constipated, and the stools, which are voided with difficulty, are composed of cheesy lumps covered with greenish mucus. Attacks of vomiting and diarrhea are frequent interruptions during the course of the disease, and at such times the temperature is apt to be raised, but usually it is sub-normal; if the diarrhea and vomiting become chronic symptoms, they are apt to increase the danger of a fatal termination. Sleep is restless and disturbed; and many hours, particularly during the night, are spent in fretful crying. A common group of symptoms connected with the nervous system is "inward spasms." When they do occur the upper lip becomes purple, somewhat everted and tremulous; the eyeballs rotate and the fingers and toes are strongly flexed. These symptoms frquently usher in true convulsions. Sometimes the nervous symptoms will predominate, and if so the case becomes more complex. Of course, in most cases there is extreme prostration; the heart's action is weak and the respirations at times almost imperceptible. There is usually a strong

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odor to the urine; a specific gravity of 1009 to 1012; and the quantity is diminished. Death may be preceded by convulsions, or result from prostration.

The diagnosis is usually to be made from ordinary starvation and from general tuberculosis. From the former it can be differentiated by its lack of response to good food; for cases of starvation will improve under a carefully regulated diet, suitable to the age of the child. But to differentiate it from general tuberculosis is very often a difficult matter. Sometimes the symptoms and course of the two diseases are so identical that it is a perplexing problem to differentiate.

The prognosis in these cases, I think, should be guarded. It is especially unfavorable during the first year of life. Most cases are intractable; but under homœopathic treatment there is new inspiration. Most cases, if seen early, can be successfully cured by change of food and constitutional remedies. The little children should never be given up unless there is very marked wasting and prostration, or some of the more serious complications arise.

In considering the treatment of infantile atrophy it appears to me that there are two problems to be solved; namely, *first,* to maintain the normal heat of the body; *second,* to properly nourish the infant.

The heat-producing power is so very feeble that the body temperature quickly falls below normal unless artificial heat is constantly applied. The effect upon these sickly infants is very serious, and their restoration to health depends, to a great extent, upon maintaining the bodily temperature steadily and uniformly. Their extreme susceptibility is something which it is difficult for one to appreciate who has not had experence in treating these children.

In order properly to nourish these cases, a diet must be selected that will be best suited to the age and digestive powers of the child, so that he may be able properly to assimilate and receive nourishment from all the food consumed.

Some authors state that the essential treatment is to promote intestinal absorption by modification of the constituents of milk. Ohers will tell you that patients (especially infants under twelve months, who have been partially or entirely hand-fed) do well upon cow's milk diluted with lime water or barley water. There should be no routine rule to follow in placing these little ones on any one food; each case should be a law unto itself; and the food selected should be continued so long as there is shown any improvement.

Even though it has not been satisfactorily proven that the morbid condition in these cases is due to a lack of absorption, the most favorable results will follow your treatment if carried out on this principle.

If the mother's milk must be discontinued, the next best thing is to

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employ the services of a wet-nurse; especially if the child has steadily lost flesh, so that it weighs but little more than at birth, and if the change has to be made in mid-summer. There are many difficulties in the way of employing wet-nurses that you are all familiar with. Next to breast-milk feeding, I believe in following Dr. Rotch's plan, placing the child on modified milk. While it is true that good breast-milk is unquestionably the best infant food, it is equally true that properly modified cow's milk is a far better food than the milk of many wet-nurses that are employed. Dr. Rotch believes that a mixture containing a low percentage of fat, a high percentage of sugar, and a moderate percentage of proteids, is the formula to prescribe for these cases, if possible. The low percentage of fat is given on the supposition that the infant will increase in weight and thrive on a small proportion of fat, providing it be absorbed. He also claims that when high percentages of fat are given to these children, they lose, rather than gain, in weight.

After modified milk, comes the selection of one of the many infant foods that are now on the market. This question will not be so hard to decide if the child's stomach and digestive power is considered; for example, we should know whether the patient needs a milk food, or one of the malted foods, farinaceous, or albuminized food.

One of the milk-foods, Nestle's is the most widely known; but all of this class contain a large percentage of unchanged starch. Of the malted foods, Mellin's is a type of the class; Mellin's food is composed principally of soluble carbo-hydrates. Of the albuminized foods, Eskay's is the most important.

There are times when the infant foods in combination with constitutional remedies are indispensable in the treatment of infantile atrophy. I have had experience with Mellin's and Eskay's foods, giving them in two separate cases throughout the entire course of the disease, with curative results.

In children between one and two years who have not been having breast-milk, but have been allowed to eat any food regardless of quality or quantity, then cow's-milk in a diluted form will probably be the best diet; the degree of dilution will vary with the age and feebleness of digestion, and it is upon this latter condition that we must base the composition of the food.

In some cases it may be necessary to discontinue all foods entirely, putting the child temporarily upon weak broths or raw beef-juice.

It is well to have the patient bathed or sponged at least once daily with warm water. In the cases that I have had, I found that external rubbing all over the body twice daily with hot cocoa-butter is of very great benefit, instructing the mothers to rub the child, preferably in the morning shortly after giving the sponge-bath, and again in the evening

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when the child is put to bed. This has been far superior in its action to either olive oil or cod-liver oil. Also, it is well to have the abdomen covered with a soft flannel binder, and the extremities and surface of the body generally kept warm by woolen clothing; in this way attacks of colic are less frequent, if not entirely prevented.

Of the homœopathic remedies that are useful in this condition, none deserve more favorable mention than *sulphur, natrum mur.*, and *calcarea phos.* Many other remedies are useful, with their special indications: as, *phosphorus, antimonium crudum, magnesia carbonica, sepia, hepar, iodine, rheum, nux vomica* and *cinchona.*

CASE 1. Baby B.; weight at birth 7 pounds. Mother did not nurse the child. From birth, this child within the first six months received six different foods, and most all of them contained a large amount of starch; the child never made any appreciable gain in weight, the highest attained at any time was nine pounds. From the fifth to the end of the sixth month the child gradually lost in weight, and became greatly emaciated. I began treatment at this time, the child weighing six and one-half pounds, or one-half pound less than its weight at birth. Physical examination revealed nothing. Her temperature was subnormal, and she had all the characteristic stomach and intestinal symptoms of infantile atrophy.

The selection of a suitable food in this case was a puzzling one, for she had been given almost all of them, and had even existed for some time on breast-milk, and two different prescriptions of modified milk.

Finally, Mellin's food was chosen, and was prepared in right proportion to her age and strength, with Pasteurized milk and sterile water. A feeding was given every three hours, two ounces. *Calcarea carb.* was given and continued throughout the course of the illness. Cocoa-butter rubs were employed. Olive oil and warm water injections were given every morning to aid an evacuation. The child began to improve from the very first and made an excellent recovery within three months. The child is still living and enjoying perfect health.

CASE 2. Baby M., aged 4 months. Mother was stout, well developed, and apparently healthy; nursed the child from birth. From the third month on the child did not seem to thrive, but instead became extremely emaciated. This case at the time treatment was begun weighed about the same as at birth. The child presented all the symptoms and general features that belong to this disease.

The child was immediately weaned; a wet-nurse could not be considered in this case on account of the circumstances of the family. Modified milk could not be obtained with advantage, on account of the great distance the family lived from the dairy; and the dairy not delivering its milk in that locality.

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I placed this child on Eskay's food, and it seemed to pick up from the very first. *Natrum mur.*, and *sulphur* were the two remedies employed in this case.

This case did not present any new symptoms or conditions different from other cases. The child is now over two years old, healthy and strong.

CASE 3. Baby C., aged 9 months. Mother thin and anemic, but never nursed the child. Baby weighed eight and one-half pounds when born. Up to the ninth month the baby had been having Malted milk and cow's-milk. When I began treatment in this case the child weighed but little more than at birth. This case exhibited all the characteristic symptoms of this disease; the child was very weak and exhausted, and recovery in this instance seemed very doubtful. I do not think the Malted milk can be blamed for the condition in this case, but I do think that the mother ruined her digestive powers by giving too much table-food to so young a baby; for if a child will get along nicely for so many months on an infant food it cannot be blamed entirely for this condition, especially when we know the mother is not particular as to the foods she allows the child to have.

I also placed this child on Eskay's food, and discontinued everything else in the way of food. She progressed rapidly, complete recovery taking place within two months. This child received *calcarea phos.* and *natrum muriaticum.*

CASE 4. Baby E., aged five and one-half months; weight at birth eight and one-half pounds. Mother well developed, large breasts, and apparently strong and healthy. This case is interesting because it proves conclusively that if the symptoms of insufficient nourishment had been recognized earlier, and the breast-milk examined, proper treatment could have been instituted and the case, no doubt, have recovered. It also shows the necessity of always insisting that the wet-nurse come to the patient's house, excepting to have her regular hours for taking out-door exercise.

The mother nursed this child to the end of the third month. Two weeks previous to the weaning of the child it developed severe intestinal and stomach symptoms; a prominent allopathic physician was called in; he prescribed without making any inquiries as to the condition of the breast-milk, saying that the child would be better within a few days. During the next two weeks she continued to grow worse, and it cannot be wondered at, because the mother continued to nurse her through this period. The infant weighed before this period nine and three-fourth pounds; after the sickness it weighed but eight and one-half pounds, or the same weight at the end of three months as at birth. She was now weaned; and without first examining the mother's milk to see if it could

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be benefited in any way. Within ten days after the weaning, the child received at least six different infant foods; having vomiting as a constant symptom, as would naturally result. Then, at this late hour, he commenced the service of a wet-nurse; her personal history was not carefully taken nor the condition or weight of her own baby considered. And can you believe that this wet-nurse's child weighed at three and one-half months eighteen pounds, and that she supplied the milk for her own and for this sickly infant of the same age, who only weighed about eight pounds. Besides all this carelessness, he did not even insist on the wet-nurse remaining at the home of the patient, but she was allowed to send the breast-milk to the house every morning and evening; this was continued each day for a period of two weeks, without any regard for antisepsis or cleanliness. You would think sufficient harm had been accomplished, but to make matters worse, he combined in equal proportions the breast-milk with one of the well-known infant foods.

I began to treat the child when it was four and one-half months old; and a pitiable sight it was to behold. She at this time weighed seven and one-half pounds, or one pound less than at birth.

It was very hard to know just what to do for the nourishment of this child, for it had received most every food now on the market worth considering. I finally concluded that modified milk would be the best food for her, and made a prescription containing a low percentage of fat, as follows:

Fat, 0.45; Sugar, 6.00; Proteids, 1.00; Lime water, 5.00.

The child gained half a pound on this prescription within the first week; during the second week it lost more than it had gained, because vomiting became so persistent. This is surely evidence that the infant's digestive power was ruined when it could not digest and absorb for any length of time such low percentages of milk-constituents. Before changing to another food I concluded to give the stomach a rest and rely on rectal alimentation as long as possible; but I soon found that the child did not even hold its own on this treatment, and went back to the modified milk, same prescription as before. This I had to abandon in a day or two on account of the vomiting, colic, *etc.* I knew by this time that I was dealing with a hopeless case, but continued treatment by giving small doses of predigested beef-juice, panopepton, liquid peptonoids, *etc.* The baby continued to fail; the atrophic condition of her muscles was very marked, the bones merely covered by skin. The child died at the age of five and one-half months, after an illness of two and one-half months.

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CONGENITAL SYPHILIS AND ITS TREATMENT

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I do not propose to discuss the disease of congenital syphilis in all its manifestations, but to touch upon some of the most important characteristics of the disorder and speak of its treatment, prophylactic, dietetic, hygienic and medicinal.

The early manifestations are of two classes: First, those cases in which the disease is developed at birth, and, second, those in which it appears from six weeks to three months after birth. It should be borne in mind that in this disease the earlier the symptoms appear the more virulent is the poison.

In the cases which are born with objective symptoms of this disease we notice at once that hippocratic face, the pathognomonic symptom of blebs on the soles and palms, fissures of the lips and anus, disturbed nutrition, and evidences of tissue changes. These unfortunate infants may be a source of infection to a wet-nurse, while the mother is not liable to infection from her own child.

This seems to prove that all mothers bearing syphilitic children of this class must necessarily have been infected, though no objective symptoms have ever presented themselves.

How and when this infection takes place is not the purpose of this paper to discuss. However, the above statement is accepted by the best syphilographers of the various schools of medicine, and I have not found on record an authentic case where such a mother has later become inoculated in the ordinary way.

Speaking of the second class of cases under this heading, those who are born apparently healthy, but presenting symptoms of syphilis at a later date, say six weeks to three months, we have an entirely different picture.

In this class of cases our suspicions are often first aroused by the appearance of snuffles, later the ear-complications, otitis, hyperplastic changes in the bones, general mal-nutrition, wasting of tissue, skin lesions appearing on the abdomen and nates, spreading over most of the body, still choosing the face, abdomen and nates as their favorite location.

Skin lesions alone are never sufficient to establish a positive diagnosis, as their character differs so much in different children. But their location, their color, and mixed variety are very suggestive. We have anything from an erythema to a pustulous form; a discrete to a confluent

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form, and in many cases furunculosis is the only skin lesion present. The visceral involvement may be either gummatous or interstitial. Interstitial hyperplasia, however, is the most common type, and affects the viscera in the following ratio of frequency—the spleen, the pancreas, the liver, the lungs, the testicles, and the kidneys. The long bones are the usual seat of syphilitic lesions, less frequently are the bones of the cranium. The bone changes are of two varieties, osteochondritis and osteoperiostitis.

Osteochondritis is characteristic of syphilis, and appears between the bone and the epiphyseal cartilage, and may materially affect the growth of the bone. Osteoperiostitis affects the surface of the bone involving the periosteum, and is usually a later manifestation of the disease.

The degree of disturbed nutrition of these poor little fellows depends upon the activity of the virus in the parent at the time of conception. The blood is always deficient in red blood corpuscles and lencocytosis is present to a greater or less degree. The nervous affection present in these cases is not extreme. This, however, is not true of children a few years older, for it is in this class that we have some of the most interesting nervous phenomena known to the profession. The foregoing is merely a statement of the conditions we most often meet in syphilis in early infancy. There are many symptoms and conditions associated with the disease at this period, which I have not mentioned, not wishing to go into the subject to that extent.

The discussion of the treatment means more than merely going over a lot of well-known symptoms and conditions known to all. In the beginning I have subdivided treatment into four heads: prophylactic, dietetic, hygienic, and medicinal. By prophylactic I mean a course of treatment which I will give to the parent or parents if called upon to treat the acute condition. It is my custom and private practice to gain control of the early manifestations as quickly as possible. If I am able to treat the initial chancre I do not cauterize, but teach cleanliness to the patients regarding the same. I do not deem cauterization of the characteristic chancre as good practice, as it seals up the open lesion and thereby prevents nature from throwing off a certain amount of virus which must necessarily be absorbed. In my experience I find that cauterization does not hasten, but aggravates, the secondary stage of the disease. This treatment, however, does not hold true in cases of mixed infection where there is a continuous destruction of tissue.

As to treatment, *mercury* is invariably indicated in the beginning. It is my custom to give this remedy at intervals for two or three years, or until the patient is entirely cured of the disease. I say cured, for I feel that we can promise this class of patients much more than we can

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those suffering with such venereal diseases as gonorrhea. Habits and personal hygiene are essential factors in the treatment of syphilis and I have never given anything but *mercury* for the first year, unless symptoms arise calling for some other drug.

You may say that one will mercurialize his patient. I think not; not if one gives proper attention to the baths, hygiene and diet. There are numerous remedies which may be indicated during the first year, and among the most common are *nux, ferrum, kali iod., arsenicum, iodine, pulsatilla, sulphur* and *nitric acid.*

Whether or not the action of *mercury* is mechanical or bacteriological, I will not discuss; suffice it to say we have equally good men upholding each theory. The proto-iodide is my favorite form of mercury, and the dose given is the smallest that will control the symptoms.

CASE. Mr. B. appeared at my office in January, '97, suffering with syphilis in the secondary stage. I immediately put him on mercurial treatment, and in eight weeks all physical signs of the disease had disappeared. Contrary to my advice, he was married the following November. Since November, '97, his wife has given birth to two children, both being apparently healthy. The parent continued treatment until January, 1900. He never presented a tertiary symptom and has enjoyed the best of health. I agree with Chapin, who says: "If the parent be subjected to early and thorough treatment, the probability of transmission of the disease will be much lessened, and such a possibility soon becomes lost with a reasonable lapse of time." The same writer also says: "Without mercurial treatment the spermatozoa can usually transmit the syphilitic poison during the first year after primary infection."

Dietetic Treatment. The most important point in the care of these infants is to maintain their general nutrition. This is not always easy to do. Often we find a mother's milk scanty, but even if plentiful it rarely furnishes an adequate food. When a mother cannot supply the proper food for her infant we turn then to the wet-nurse, but on account of the dangers spoken of above, this is not permissible. In preparing a food too little attention is often given to the weak digestive powers of the child, and to the variety of food really needed. It has been my experience that a simple cream mixture is what they can most easily take care of. Fat and sugar are essential to them, and is usually well digested if not given in larger proportions than 1 per cent of casine, 3 to 4 per cent of fat and 6 to 7 per cent sugar-of-milk. Unfortunately all dairies in large cities do not furnish a suitable cream for making up this mixture. If we can obtain an article of cream containing 18 to 20 per cent fat we are able by the addition of water and milk-sugar to prepare a food suitable to a large majority of these infants. By maintaining a high

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standard of nutrition the possibility of dyspeptic disorders is diminished, and our treatment will result in greater benefit to the child.

Hygienic Treatment. Under this heading I wish to impress upon your mind the absolute necessity of cleanliness. Baths, fresh air, and sunshine are necessary for an infant in health; the more, then, should these little sufferers receive an abundance of each. By maintaining a high standard in hygienic care we not only aid the child's digestion, but also assist nature in eliminating the poison.

Medicinal Treatment. We have many remedies that are of utmost importance in this form of the disease, and I may head the list with *mercury.* I do not belong to that class of physicians who claim that the use of *mercury* is always necessary in congenital syphilis. Mercury often serves us well in mucous ulcerations, as also does *kali iod. Nitric acid* relieves syphilitic pains of rheumatic character, *mercury and kali iod.* may also be indicated for this symptom. *Arsenic-iod.,* and *calcarea iod.* may be called for in glandular involvement that *kali iod.* will not reach.

Phytolacca decandra and *berberis* are of value principally on account of the percentage of *potassium iodide* they contain. *Silicia, sulphur* and *zincum* are valuable in nervous disorders. *Kali iod.,* too, is often found valuable in these cases. *Rhus, pulsatilla* and *sulphur* are excellent remedies to clear up the skin manifestation. *Hepar sulph., nitric acid* and *aurum* are of service in osseous lesions. Much may be said on remedies, and one of many drugs may be indicated. By adhering closely to the indicated homœopathic remedy the best results will invariably be obtained.

DISCUSSION:

F. W. WOOD, M. D.: I am not a dualist, and cannot discuss this paper as a critic, but merely to emphasize some of the many good points that appeal to me.

One of the first is the prophylactic treatment of congenital syphilis. It should date back not only to the time of conception, but a year, or years, previous to that time. By this I mean to say that you must treat the disease in the parents, from the time of the initial lesion, or discovery of the malady, until a cure is pronounced. It is well to bear in mind that syphilis is in many cases not a distinct venereal disease; by this I mean that the primary lesion did not occur on the genital organs. Buckley states that, in his private practice, nearly fifty per cent of his cases of syphilis in females have had extra-genital lesions; while Fourneir states that twenty per cent of his syphilitic females in private practice gave evidence of extra-genital lesions. In that case, especially if the patient has some constitutional dyscrasia, or some form of constitutional disease, often the condition is not recognized as a case of syphilis until it is too late, the patient is married and gives birth to unhealthy or syphilitic children.

Further, the transmission of syphilis, according to Beck, is spoken

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of as being direct by the spermatic fluid, the spermatozoa carrying the virus. Taylor states that he does not believe that syphilis is transmitted from the mother to the child by way of the placential circulation; however, we find as equally good authorities stating that syphilis is transmitted by the placental circulation. Five little rules might be mentioned here which appeal to us all from a prognostic standpoint: *First,* if the father has syphilis and the mother is well, they are likely to get a syphilitic child. *Second,* while if the mother is syphilitic, and the father is well, although he may not contract it, the mother will give birth to a syphilitic child. *Third,* if the mother and father both have syphilis, and it is in its active stage, and the mother becomes pregnant, she will probably lose the fetus, or, if carried to full term, it will early bear the marks of syphilis. *Fourth,* if the father and mother be well and healthy at the time of impregnation, and the mother contracts syhpilis during the nine months, the child will bear a syphilitic taint. *Fifth,* if the father and mother have had syphilis, but have undergone treatment for three or four years, they may beget a healthy child. From this we can say the treatment prior to conception is of the utmost importance from a prophylactic standpoint.

The symptoms in the child are often manifested as early as the second or third week. Among the first lesions noticed are the abrasions of the nasal mucous membrane, the excoriation of the rectal mucous membrane observed by evaginating the rectal walls. These give evidence of the catarrhal tendency even before there are noticeable skin lesions or profound nutritional changes. Aploplectic symptoms are almost always fatal, and mean death to the child within three to four months.

A case came under my observation for delivery. After close questioning, examination and blood-tests, evidence of syphilis was ruled out. Examination of the vaginal tract failed to show signs of former lesions. The child was delivered, seemed normal and fairly well nourished at first, but later, within two weeks, gave evidence of syphilis. The symptoms of syphilis developed very rapidly, and soon the child gave evidence of profound nutritional changes. On autopsy almost every known pathological lesion had developed in the short space of ten weeks. Previous to death the blood examination showed distinct pathology of congenital syphilis, decreased relative number of polymorphonuclear leucocytes, increased number of lymphocytes and last myelocytes, which I have found to be a fatal omen in these cases. The father, after close questioning, admitted that he had had a primary syphilitic lesion about two years before, yet the mother gave no evidence of the disease. We might state further that the principal remedy used in this case was one of the forms of *mercury,* the symptoms produced by this drug being allied closely to this disease. Hahnemann, in his work on *Venereal Diseases,* states that he believes that *mercury* should be given in doses sufficient to produce mercurial fever in order to cure syphilis. I, however, believe that *mercury* can be given in small doses, even as high as the 6x, but lower if necessary to control the symptoms. There is a great deal of opposition to the general use of *mercury* in syphilis, but I am in favor of its use, and can find no better authority than Hahnemann. There are other remedies that will give excellent

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results, such as *potassium-iodide, berberis, phytolacca dec., pulsatilla, nitric acid, etc.*

The nutrition of the patient must occupy our attention as one of the most important steps in the treatment. I have found that mother's milk, or the milk of a wet nurse, is the best that can be used. If a wet nurse is used it must be borne in mind that one must be obtained that has had the disease and has been relieved of the symptoms of syphilis, and in a good state of nourishment; the flow of the milk about the age of that of the mother. If modified cows' milk is to be used it is necessary to remember the season of the year according to which the percentage of cream varies. Borden's condensed cream contains from 18 to 24 per cent of cream, according to the season as mentioned above. In writing the prescription for modified mixture I generally use 2 ozs. cream, ½ to 1½ ozs. milk, 6 ozs. water, ½ to 1½ ozs. lime water, according to the disturbance of digestion, and 3⅜ grms. lactose. This will make a prescription corresponding very closely to the percentages given in the paper.

The nutrition must be maintained in congenital syphilis or you will lose the little patient. If you want to save the child you must begin early and watch the digestion carefully for intestinal complications. If you save the child for the first three months, it has been my experience that the child is apt to survive the disease. However, the treatment must be continued, and the nutrition must be maintained at as high a state as possible until the child reaches its majority, or some complication will take him away in early youth.

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SECTION IN

OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY

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MOUTH-BREATHING, ITS DANGERS AND METHODS OF CORRECTION

JOHN B. GARRISON, M. D.
NEW YORK

One does not have to be a very close observer to notice, in the daily walks of life, many, who, from inability to easily do otherwise, breathe most of the time through their mouths.

Some of them are, in spite of this abnormal manner of taking the air, apparently healthy; but many others are, on the other hand, narrow-chested and illy developed in more ways than one.

When mouth-breathing becomes necessary in a young child, it naturally suffers because in losing the respiratory function of the nose the air breathed is not warmed, filtered or moistened as nature intended it should be before entering the lungs.

At first the breathing is through the mouth only at night, perhaps, but shortly every little exertion during the day compels the mouth to open in order to receive the supply of air that is demanded. The patient snores at night and wakens in the morning with mouth and pharynx parched and dry. The sleep becomes restless, and frequent sore-throats are noticed. The breath becomes foul and the taste is unpleasant. The face of the child alters in shape and becomes larger and narrower. The palate, from improper development, becomes very highly arched, and the permanent teeth come in irregularly, and the upper front ones frequently project outward so as to be a marked deformity. As they do not receive proper rest because of the restless nights, they are stunted in growth and are far from robust. We have dullness of hearing, and an otitis media is often an accompaniment. They do not do well in school and mentally are inferior to their fellows.

Stuttering, stammering, incontinence of urine, epilepsy and chorea are noticed in some cases where nasal stenosis is present.

Of course these conditions do not find a place in every child who breathes through its mouth, but they are all found in some of them, and should be thought of.

The condition causing the mouth-breathing may be a deflected septum, adenoids of the pharynx, hypertrophied faucial tonsils, nasal polypi, foreign bodies in the nose long neglected, ridges or spurs on the septum, hypertrophy of the nasal mucous membrane, tumors of various kinds.

As soon as a child, or adult, is noticed to be breathing through

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the mouth any considerable part of the time, a competent physician should be consulted as to the cause. That being found, no time should be lost in having the defect corrected.

In children a deflected septum often follows a simple fall upon the nose, and all injuries to the nose in a child, however slight they may be, should be carefully examined at once, and if any injury is apparent, it can be very easily repaired. There are so many deformities of septi found where there is no history of any injury that it is not at all unlikely that childish bumps, cried about at the time, but soon forgotten, were the starting point of the later developments.

The larger part of the deflections that have come under my observation in children have been of the cartilaginous portion, and have proved easy to correct.

I am in the habit of placing the patient under a general anesthetic, washing out the nasal cavity with a one-to-six solution of electrozone to make it aseptic, lightly swabbing with a one-to-two thousand solution of adrenaline, to limit the hemorrhage, and then, with a scalpel making an incision directly through the greatest point of convexity in its long axis, this to be crossed in the middle with an incision at right-angles. Then, with the finger in the occluded side, press through this opening and break the four segments at their bases, making four triangles. Then, with a nasal forceps, thoroughly loosen the septum at its base and the septum will then be found to be easily moulded into the proper shape with the finger.

After removing the clots that have formed in the nares, I then introduce a hollow nasal splint into each side, choosing the size that will hold the septum in place without too much pressure. These should be left in position for about twenty-four hours, when they should be reremoved and the nares gently cleansed to remove any blood or secretions, but avoid producing any hemorrhage if possible. It may be wise to use a solution of cocaine before attempting to cleanse the nares, because of the pain attending in nervous children.

After leaving the tubes out for an hour or two they should be replaced, after thoroughly disinfecting them and having anointed the passages with a solution of calendula, which I prepare as follows:

℞ Succus Calendulæ ..... ʒ iv.
Glycerinæ.
Aqua dest. ..... *aa*, q. s. ℥ iv.
M.

This has proved in my hands to materially assist in the healing process. The tubes should be removed and cleaned each day, and after the second day they should be left out from three to six hours each day. During the third and subsequent weeks they need not be worn at all

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during the day, but at night they should be continued to the end of the fifth or sixth week to insure a good strong cartilage that will not sag, which will frequently be the case if the supports are removed too soon.

Adenoids are a most frequent cause of mouth-breathing in children, and should always be treated with the appropriate homœopathic remedy as soon as they are known to exist. That is, the constitutional remedy should be administered, and if given, will produce many a cure. *Bacillinum, calcarea carb., calcarea phos., chamomilla and lycopodium* have been frequently the remedies that have done me good service. At the same time I always direct the employment of a bland oil, like benzoinol, in the nose, to prevent the secretions from remaining and irritating the mucous membrane.

This may be introduced by means of an atomizer or nebulizer, or dropped into the nares with a glass medicine-dropper. The latter method is advised with my dispensary patients on account of its inexpensiveness, and is very effective.

When medical treatment fails to relieve, an operation is to be advised for their removal. This I always do under a general anesthetic, as I believe it better to do so than to excite the child by the restraint and sight of blood, as well as to give myself a feeling of having time enough to properly assure myself that all the adenoid tissue is removed; something that is necessary and likely to be hurried over if the patient is screaming and fighting for a release.

I usually operate with the patient on the right side, so placed after the anesthesia is perfect, and I usually use chloroform for the purpose as being more easily taken, quicker to recover from and, in my opinion, fully as safe if properly administered.

The ideal manner of administration is to combine the chloroform with oxygen or air by means of an inhaler provided for the purpose, but if an ordinary Esmarch mask is used, I have the chloroform carefully dropped on it from the start, *not to exceed one or two drops per second.* I have never seen anything approaching danger when this precaution has been taken.

Having the patient supported on the right side by means of sand bags placed at the back, the mouth-gag is placed in the left side of the mouth by my assistant, and I introduce my left index-finger back of the palate to locate the masses of hypertrophied glandular tissue and then introduce, closed, the cutting part of a Concannon forceps, which will usually bring away the largest portion in one sweep. Two or three times is usually sufficient to use these, and then I am in the habit of substituting the Loewenburg forceps to remove any smaller portions remaining. Many operators depend upon the curette for the removal of

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the remnants, and with great success, but I am, possibly, more handy with the forceps and prefer them. After assuring myself that all the enlarged glands are removed, I wait a few moments for the hemorrhage to subside, scarcely ever finding it necessary to use any hemostatic, have the blood cleaned from the face, and place the patient in bed, allowing what food they desire as soon as they find an appetite, which is frequently in from four to six hours.

The faucial tonsils, unless enormously hypertrophied, do not often cause mouth-breathing. Where there are adenoids, especially in the lower part of the pharynx, coincident with the enlarged tonsils, the removal of the adenoids frequently causes a marked diminution in the size of the tonsils.

If the tonsils are at all adherent to the pillars, the adhesions had better be loosened by means of a knife having a cutting edge about one-half inch long, at right-angles with the shaft, and sometimes with the point curved one way or the other to make it convenient for use on the right or left side, using them in pairs. After thoroughly loosening the tonsil, any form of tonsillotome preferred by the operator may be used, my preference being one made by Ermmold, being made in three pieces, convenient for purposes of thorough cleansing and disinfecting. It is always best to get a history of the patient as to the tendency to hemorrhage before operation for hypertrophied tonsils, as hemophiliacs prove to be dangerous subjects.

The ordinary hemorrhage is usually soon subdued, and if a little prolonged, a pledget of absorbent cotton soaked with peroxide of hydrogen pressed against the cut surface for a few moments will generally be all that is needed. The patient should be confined to bed for a day or so, and not exposed to draughts until the healing process is well along. The diet may be what the soreness will tolerate, but usually semi-solids will be necessary for perhaps three days.

Nasal polypi, when present, are to be removed with the cold wire snare. The instrument I find best is composed of a stylet and canula, the stylet having two holes at one end for the fastening of the wire loop, and a thumb-screw at the other to tighten and draw up the loop as required.

First apply sufficient cocaine in a ten per cent solution to prevent pain, and just before commencing, spray a little adrenaline in a solution of one to two thousand, to prevent undue hemorrhage. Also disinfect by spraying the nostril with electrozone, 1 to 6.

Having threaded the stylet with the wire so as to make a loop of about one inch long, introduce it so as to engage the tumor, which is something that cannot be told, but must be gained by practice alone. Sometimes it is very easy to catch and bring away the polyp, while in

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other cases it will take a long time to encircle it. Once engaged, draw the stylet back as far as it will go, and then slowly tighten the screw at the end until it is finally loosened and comes out. If the tumor remains within, it may be removed with a pair of angular forceps. As much of the attachment as possible should be removed to prevent its reappearance.

Foreign bodies are sometimes not discovered until they have been in the nose for a long period of time. When diagnosed, cocaine should be introduced on absorbent cotton for the double purpose of producing anesthesia and to dilate the canal by reducing the hyperemia. Then, with a blunt-pointed probe, having the end bent at right-angles about a quarter of an inch from the point, the body is engaged by passing the probe above it and drawing forward, which will usually be successful in securing it.

Ridges and spurs of the septum, whether bony or cartilaginous, or a combination of the two, are best removed with the saw when they give rise to symptoms of obstruction.

A saw that can be reversed in the handle, thereby making the same blade useful for cutting upwards and downwards, is the best for general use. Where a motor is available, a mechanical saw, such as Sheppergrell's or Brown's, is both convenient as well as a saving of time and pain. The work is done so rapidly that the patient is hardly aware of the pain before it is completed.

Thorough anesthesia by means of a ten per cent solution of cocaine applied on absorbent cotton introduced against the parts to be removed. The spraying of a little adrenaline solution, one to two-thousand, will prevent the blood from flowing so that the course of the saw can not be seen. After the removal of the part it is necessary that something should be introduced to prevent the raw surface from coming in contact with the opposing side, as an adhesion may take place if any erosion of the mucous membrane exists, which is quite likely after the operation.

For this purpose, nothing is better than a strip of sheet celluloid, rendered aseptic and placed against the raw surface, sufficient lintine or gauze being on the other side to firmly hold it in place. This, also, will serve to prevent hemorrhage. After-treatment is directed to keeping the nares clean until healed. Hypertrophies of the inferior or middle turbinates may be treated with the galvano-cautery, electrolysis, chemical cautery by means of acids, tri-chloracetic and chromic being the usual ones, or by means of the knife, saw or cold wire snare.

In using the galvano-cautery, a good storage-battery is necessary, unless the street current with a suitable transformer is available. Having the parts well cocainized, introduce a flat cautery-knife, cold, into the naris, and, being careful to produce only a *dull red heat,* press lightly

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against the hypertrophy and draw slowly outward, leaving a white eschar. The amount of heat used decides the result, as *a low heat causes the most contraction always.* These treatments should not be repeated in from ten days to two weeks.

Electrolysis can be produced by having a good galvanic battery and the most effective work is done by means of the bi-polar needle of Sheppergrell, which introduces both the positive and negative poles into the tissues and is much more effective, as well as more rapid in its action, than where one pole is introduced with the other on the surface, at a distance. Before inserting the needles they should be insulated to within a half-inch of the points with a light coating of shellac varnish, to prevent the electrolytic action upon the points of entrance. If a single needle is used, it should be of steel and be attached to the negative pole. The positive needle should always be made of gold or platinum.

Tri-chloracetic acid may be used by first applying cocaine to the mucous surface to be treated, then with an applicator best made of a copper wire about one-sixteenth inch in diameter and long enough to be handled easily. This is slightly flattened about half-an-inch at one end, and on this a few crystals of the acid (which must be kept in a glass-stoppered bottle) are laid, and then passed through the flame of an alcohol lamp, using just enough heat to melt the crystals, which will then cool adherent to the applicator. Wipe off any particles that are not firmly adherent with absorbent cotton, and then, after wiping the mucous membrane of the nose thoroughly apply the acid lightly, when a white eschar will be seen. Then, without any delay, apply a strong solution of sodium bi-carbonate, which has been prepared beforehand, to prevent the spreading of the acid, which is the greatest danger in the use of the acids.

Chromic acid is used in about the same way except that the probe I always prefer is made of silver, and is probe pointed. This should be heated in the flame of the alcohol lamp before plunging it in the bottle containing the acid, when the heat will cause some of the crystals to be retained. Holding this in the flame of the lamp for a moment will cause it to fuse in a smooth, round bead, and it is ready for use the same as the other. The same directions for the bicarbonate of soda solution apply here as with the tri-chloracetic acid.

The posterior hypertrophies of the inferior turbinates are removed with specially prepared forceps, or the cold wire snare. The latter is the method that I always use. The ordinary snare described in another place, is used and the loop can be placed either by using a rhinoscopic mirror to locate the enlargement, and wire or the finger may be placed behind the palate to assist.

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The saw and cutting instruments are used to remove portions of the inferior turbinates sometimes, but the greatest care must always be used to prevent more than is really necessary from being taken, as the tendency to atrophy after too much has been removed must not be forgotten.

Tumors should be first of all diagnosed as to their malignancy or non-malignancy and operative procedures decided upon as seems proper. Fibromata and papillomata are best removed with the snare. Angiomata are safest to be removed with the galvano-cautery snare, as the hemorrhage may be severe if other means are used. Osteomata demand the chisel and gouge.

Other tumors are likely to demand surgical measures that must be decided as each particular case arises and the further discussion would not be profitable in this paper.

Discussion:

Dr. Edward Beecher Hooker: The idea of having a Section of this character make a report to the Institute serves to bring before the Institute certain matters connected with the specialty of interest to the Institute and to the general practitioner. I recognize in the audience a number of gentlemen connected with the special societies, but the largest number are general practitioners, and, therefore, in the discussion of this paper I shall allude more to matters which are of interest to the general practitioner than to the specialist. In the first place, the general practitioner can do a great deal of work that is often sent to the specialist, especially in sections of the country where no specialist is easily accessible, and where the conditions are not serious enough to demand the sending of the patient away. Now, the first thing to do in a disease of this character, as in all others, is to make your diagnosis, and in order to make a diagnosis of obstruction of the breathing passages you must have a good light, and there is no light to be compared to that which you obtain by reflection from a head-mirror. In the city, or in any portion of the country where gas can be obtained, there is no light superior to that which can be reflected from a Welsbach burner. The ordinary electric lamp with condenser will answer admirably if you cannot get a Welsbach, but you can be away from gas or electricity and still get a serviceable light. There are portable electric lights which can be held and reflected from a head-mirror. You will not find very serviceable illumination by an electric lamp in the handle of your instruments. For this work I have found such light far inferior to that reflected from a hand-mirror. Now, having a good light, make the diagnosis as to the cause of obstruction. You will find it in the nose or pharynx. Leaving out the question of foreign bodies, if in the nose it will be connected with the septum, turbinated bodies or it will be polypi. If in the pharynx it is caused by adenoids, or rarely from immensely hypertrophied faucial tonsils. Turning now to the cause of obstruction in the nose by the septum. There may be an actual deflection, or there may be only a bulging and thickening of the septum. You can remove the projection and angularities very well by various instruments, but it

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is quite a simple matter by means of the nasal saw. Very often, if you have removed these angularities and projections and spurs, you will then have room enough, and a more protracted operation under ether or chloroform will not be necessary. If the septum is not the cause of the obstruction it may be in the turbinated bodies. They may be reduced by chromic acid, which in very young children is effective. If that is not sufficient, electrolysis should be employed. If that is not powerful enough you may have to remove a portion with the saw or forceps, or you may possibly have to use the snare. If the trouble then is not found in the septum or turbinated bodies, it will be caused by polypi. These are best removed by the cold wire snare, the closer to the origin the better, although I believe that very rarely does a new polyp spring from the stump of an old one.

GEO. B. RICE, M. D.: I wish to say a word regarding the septal operation described by Dr. Garrison in his excellent paper.

The performance of this operation (generally known as the Asch operation) on children is not always a safe procedure, particularly in the case of strumous and poorly-nourished children. Frequently the slight pressure of the splint necessary to keep the septum in proper position, is sufficient to cause sloughing. The splint must then be removed to save the total destruction of the cartilage. You have then subjected your patient to the shock of the operation, to a great deal of discomfort, and have accomplished nothing. I would therefore suggest that cases for such operation in children be selected with great care, and that in every suspicious case a course of preliminary treatment be instituted. Dr. Garrison has advocated the use of forceps for the removal of lymphoid tissue from the naso-pharynx. I strongly object to the use of forceps for this operation, unless the instrument is used by an expert, and even then, I believe great caution is necessary. In unskilled hands, it is very easy for the operator to grasp the septum, Eustachian prominence, or a loose fold of mucous membrane, and thus do irreparable damage. If I may be pardoned for alluding to my own work, I would like to say that in the last year I have done this operation over two hundred and fifty times, and that in no case have I found it necessary to use any instruments except the modified Gottstein curettes, and I feel confident that the operation has been thoroughly done in every case.

THOS. M. STEWART, M. D.: You have listened to an excellent paper by one of the specialists of the East, who has given his experience for the benefit of the general practitioner. I only want to enlarge upon one or two points that may be of help when we think of the Cleveland meeting and have some case along this line, and refer to the Transactions for the points which have been so admirably presented. We have a polypous case and remove several polypoid growths from each nostril. One of the points which I wish to bring out is, that it often requires more skill in the after-treatment of the case than in the operation. You may not think so until you find out by experience. You will very often find, in order to cure a polypoid growth, that you will have to go a step further than indicated in the paper, and that is to remove the

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middle turbinated bodies to get at the ethmoid cells, the seat of many difficulties. One more point: You may have operated yourself, or had some specialist operate for you, in a case of removal of the tonsil and had hemorrhage. I believe it is the duty of the specialist to leave in the general practitioner's hands for the use of himself, the nurse, or parents, a little printed slip giving the points to be followed in the after-treatment of these cases.

J. B. GARRISON, M. D.: As regards probable perforation of the cartilaginous septum, following operations upon children who are poorly nourished, the utmost care, both in operating and subsequent treatment, must be taken. The application of pledgets of cotton saturated with bovinine is of great benefit in these cases.

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THE IMPORTANCE OF CORRECTING EYE-STRAIN

FRED. D. LEWIS, M. D.
BUFFALO

This subject has been considered so frequently in the last few years by men of the greatest prominence in their special line of work that it may seem presumptuous on my part to elect to review the subject again. However, my experience has taught me that its importance is not yet as fully appreciated by the family physician as it should be There are more ill-effects following an eye-strain of any length of standing than would be believed, unless such conditions were not presented daily to the specialist. Or, in other words, it is surprising how many cases of suffering that have been treated or endured for years, disappear of themselves when the cause, when it is the cause, is removed, namely: eye-strain.

We all know that very many headaches are due to defective vision, but do we all know that indigestion, heart troubles, kidney affections, or in fact any trouble of any length of standing, may be due to the same cause? When I speak of any troubles, I refer, of course, to old constitutional conditions, not contagious or infectious diseases. And yet even these, as I shall explain later, may to a considerable degree be the result of an eye-strain.

Let us for a few moments consider what eye-strain really is. It may be from several causes, either hyperopia, astigma or muscular unbalance. Now, when any of these conditions exist, nature makes an effort to correct them by the action of the ciliary muscle in the case of the first two, and by a spasmodic action of the weaker muscle in the last. The result of this unnatural muscular action to the patient is a loss of nerve energy. The sense of sight is more constantly in use than any other sense we possess. Now, with defective vision, even of a small degree, that can be easily overcome, the loss of nerve energy in the course of days, weeks or years is simply enormous. This loss is, not infrequently, so much that other organs are deprived of a sufficient amount to conduct their functions. It is also a by no means uncommon occurrence to find a patient suffering from some functional derangement, where the eyes are the cause, without the slightest thought that the vision is anything but perfect. This may be accounted for by the fact that said patient has received as part of his inheritance an organ weaker than the eyes that has in consequence given warning of inability to perform its duties before the eyes have complained. Thus, with a congenitally weak stomach, in-

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digestion, due to lack of nerve force, in consequence of waste through eye-strain, although the indigestion might be the only symptom of which the patient complains, would disappear on correction of the eyes. Congenitally weak kidneys, as I saw in a very marked case, resulted in rheumatism, while the patient was unaware of any eye trouble. This case had 20 degrees of hyperphoria, the correction of which resulted in the gradual abatement of the rheumatism.

Now, if individual organs are so profoundly affected from this cause, is it at all unreasonable to suppose that, when all organs are comparatively strong, the whole system may be so depleted that the subject will have the least resistive power to repel any contagious or infectious disease that happens his way.

Again, if the child is attempting to overcome an eye-strain during the period when all efforts are bent towards tissue-building, and this age is when the child is attending school and using the eyes most constantly, can we not justly draw the conclusion that the bone and muscle-building will be hampered and the child develop into an imperfectly, or, I should say, undersized specimen of humanity? Now, as nurserymen select the smallest seeds to produce dwarfs of any given tree, is it too much to suppose that this under-development may not be handed down through generations of unborn children? This whole argument leads finally to the question I wish to propose. Do we do justice to our patient, or have we made a complete examination when we do not know exactly the condition of the eyes? I feel satisfied that in many cases where I have corrected focal or muscular errors of the eyes, I have saved patients many dollars in doctors' bills that would have resulted from their systems being in receptive condition for diseases, that with the saving of the nerve force, they came in contact with and repelled.

I think it wise for every one to have a complete and thorough examination of their bodies at regular stated periods that disease may be discovered and fought in its earliest stages. Such is done in high-bred cattle; the tuberculin test being tried at regular intervals to detect tuberculosis, and I think our patients deserve at least as conscientious care as is given to stock. This examination I consider incomplete without testing the eyes. It is not at all an uncommon thing to have patients referred to me by their physicians who insist upon it, to tell me that they are not aware from any trouble in them that they have eyes; and yet on examination to find quite enough there to account for all their suffering. In olden times people never thought of consulting the dentist until there was evident trouble with the teeth, but to-day most people have learned to have the teeth examined regularly to anticipate trouble. In my opinion, the eyes are of just as much importance as the teeth, and it should not be necessary for them to cry out for help before an oculist is seen.

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DISCUSSION:

J. P. RAND, M. D.: Dr. Linnell has asked me to open the discussion on this paper because I am not a specialist, but a general practitioner, and the general practitioner is not supposed to know or believe more than half that the specialist teaches. There are reasons for this, but I will not speak of them now.

To come to Dr. Lewis's paper. We all know that there is such a thing as nerve-strain from lack of accommodation of the eye, and various other causes. But because a person has a slight defect in vision it does not necessarily follow that he should wear glasses. Our specialists never speak of it, but yet it is wholly possible that the nerve-strain from the mechanical irritation of the bows may cause more disturbance than from the defective vision itself. This is on the supposition that the lens itself is properly adjusted and a perfect fit. But every specialist knows that many a lens is not a perfect fit. The patient won't tolerate the glass that is mathematically correct, and the difference between the average and the best fit is what the ordinary patient has to put up with in addition to the mechanical irritation of the bows themselves.

It is a good thing to magnify one's office, to believe one's self, but there is such a thing as overdoing it. There is a great difference between *post hoc* and *propter hoc*. A physician prescribes for one condition, and the patient is relieved of some apparently remote symptom, and straightway the physician thinks he has cured him; and perhaps he has. Now, in the paper that has just been read I don't know exactly what the doctor means by a "congenitally weak kidney," and if such a condition really existed I doubt if it would produce rheumatism. To me it looks like a stretch of the imagination, in view of the many factors that might enter into the case, to claim or believe that the rheumatic condition was cured by wearing glasses. I have not had any experience in cases of this kind, and I know I am incompetent to judge, but I honestly think there may have been some other agent in the recovery quite as potent as the wearing of the glasses. It is a good thing, however, to have our attention called to these things. It makes us observing. It makes us think. And the doctor has certainly given us much to think of in his very interesting paper.

I fully agree that persons should be examined once in a while for evidence of disease, but I wouldn't do it very often lest the subject should die of nervous prostration while waiting for the disease to develop. In conclusion, I would say that while the general practitioner may be considered by some as "a jack at all trades and master of none," yet if he serves to correct the over-enthusiasm of the specialist in the various departments of medicine he will not have lived wholly in vain.

DR. C. GURNEE FELLOWS: As to the question of putting on glasses in early childhood, I agree with the Doctor when he says nervous prostration may arise from the wearing of glasses, and oculists, if they are honest physicians, as all should be, will not put glasses on children unnecessarily. It is a question of physiology and hygiene, and I believe the general practitioner can help immensely by watching the curriculum of our public schools, that children are not sent to school too early, before their eyes are formed, and not allowed to fuss and fool with

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letters, pictures, etc., at the age of two or three years, in kindergartens. I believe we keep them away from the oculists if we keep them away from over-study. Of course, it is just as much the function of the oculist to prevent patients wearing glasses, and this may often be accomplished by sending them back to the general practitioner, who looks out for their diet or orders a vacation, and when the ear, nose and visceral organs, or whatever organs are diseased, resume their normal functions, the eyes will take care of themselves.

J. E. Welliver, M. D.: I am not a specialist. I am a general practitioner, but I have given some attention to this study, the study of the eyes and the study of refraction. I believe there are many children who require their refractions corrected by the use of glasses, and especially those who have astigmatism, even though of very slight degree. Some, also, who have quite a considerable astigmatism, will not tolerate glasses. They see badly, but just as well without glasses, and their general health does not seem to suffer. I believe general practitioners everywhere should pay more attention to this specialty. It is no small thing to know when a patient is myopic or hyperopic, but by careful study and practice you can make it out yourself. It is not necessary to go to a special school for that purpose. You can always tell when to send a child to a specialist, but if it has any of these defects to any degree it is necessary to correct it. In hyperopia, we know after the age of forty-five or fifty how cumbersome glasses become for us, and in children the annoyance that may result from their inability to overcome that itching and accommodation. If you persist in their wearing glasses I believe they sooner come to the age when they cannot get along without them, and it is a question in my mind, although it may be well settled among specialists, whether a child should be forced to wear glasses for a mild condition of hyperopia, even if it does not give rise to any nervous eye-strain.

E. B. Spinney, M. D.: I have been many years in general practice, and I found it to be an imperative necessity to become generally familiar with refraction. I believe I have made some remarkable cures that otherwise I would have been unable to control at all. I believe the time has come when the general practitioner should become familiar with this subject. I believe this section should be always before the general practitioners, or they before it.

Thos. M. Stewart, M. D.: It has occurred to me that another suggestion might be made; that children wearing glasses to-day will control their trouble to a very large extent, and will be enabled to get through life later on without glasses, or with such change in refraction as to make it a simple matter in the future as compared with forcing them to put on glasses. One other point: If general practitioners will send their patients to the specialist, eye, ear or throat, with this requst, "Find out what is the matter, tell me, or let me understand what the treatment is, and when through with his case return to me," they will avoid having the patient slip into some other practitioner's hands and prevent the specialist from doing a little general practicing on the sly.

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F. D. Lewis, M. D.: One or two points. First of all, in regard to the irritability of wearing glasses, I find where that occurs it is due to the fault of the optician—badly fitted frames. They should be sent back again and again, if necessary, to have the frames adjusted properly. You will see that the bows of my own glasses are irregular, to fit into the little hollows back of the ears, which would tend to cause irritation. In regard to the frequency of examination, either of the whole body or a part of it, it is my practice to tell my patients, after fitting glasses properly, to come back at the end of two or three years; if not giving any trouble, to anticipate trouble. It is one of the greatest pleasures I experience to have a patient come to me to see if their eyes are right and be able to tell them they have absolutely perfect eyes, but it is a fault of the optician to fit all children with weak glasses for the sake of selling a pair of gold frames. I have seen too much of that. In regard to a small degree of hyperopia, as it is a part of my practice to refrain from putting glasses on, I believe it is wise to have the eyes work to have them overcome a small degree of hyperopia, simply for eye-exercise.

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INTUBATION VERSUS TRACHEOTOMY

E. H. LINNELL, M. D.
NORWICH, CONN.

Tracheotomy and intubation may be termed emergency operations. They are demanded quickly; there is but little time to consider their indications and comparative merits or demerits, and often, especially in small towns, the aid of a specialist cannot be obtained without dangerous delay. The general practitioner then should be able to perform either operation when occasion requires. It may be, yes, it usually is, a question of life or speedy death where operative interference is demanded, and hesitation or incompetence on the part of the medical attendant may be fatal.

I have thought, therefore, that a few moments devoted to a discussion of the indications for and against these operations and their comparative advantages might not be unprofitable. What I have to say is based not so much upon my own experience as upon my observation and instruction in the Vienna clinics.

Briefly, the introduction of a tube into the larynx through the mouth, or into the trachea through an external opening, is called for in conditions of threatened or absolute asphyxia from obstruction of the upper respiratory apparatus. Such conditions may be edema of the glottis, croup, idiopathic, spasmodic, diphtheritic, or attending the exanthemata, laryngismus-stridulus, morbid growths, etc.

Given a condition of asphxyia where operative interference is demanded, which shall it be, tracheotomy or intubation?

Briefly, the advantages of intubation may be said to be:

1. Quickness of execution.
2. The absence of an external scar.
3. Increased expectoration.
4. Reflex stimulus to respiration.

Its disadvantages are:

1. Danger of increased stenosis when there is a loosely attached membrane, either by shoving down the membrane and thus closing the end of the tube, or by the membrane occluding the tube during respiration.

2. Increase of the stenosis by placing the tube in the esophagus instead of in the larynx. This objection may seem more imaginary than real, but anyone who has tried to make the operation on a struggling child with a flabby, depressed epiglottis, a long throat, and a short finger of the operator, will appreciate its force.

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3. Danger of the child's biting off the thread and thus rendering the speedy removal of the canula by the attendant in the absence of the physician difficult or impossible.

4. Making a false passage or perforation of the larynx.

5. Decubitus, or necrosis from pressure.

6. Atelectasis, evidenced by retraction of the abdomen in the effort to breathe.

The indications for tracheotomy may be summarized as follows, viz:

1. Where, after intubation, the respiration remains difficult; or

2. Where, after using the tube for a period of two or three days, the breathing still remains difficult in the intervals of its removal.

3. Where pneumonia exists as a complication.

4. Where the fever is high continuously, 102 to 104 degrees F. In such a condition the danger of decubitus is greater.

5. Septic diphtheria. (Danger of decubitus.)

6. Where there is stenosis of the pharynx from swollen tonsils or occlusion of the naso-pharynx with false membrane, in which case, of course, intubation would be ineffectual.

The disadvantages and dangers of tracheotomy are:

1. Necessity of an anesthetic.

2. Danger of asphyxia by stretching back the head. This danger may be lessened by making a previous intubation.

3. Hemorrhage.

4. Requisite after-treatment.

5. Danger of wounding the posterior wall of the trachea.

6. False introduction of the canula, in front of the trachea, between mucous membrane and cartilage, or under the false membrane.

7. Secondary hemorrhage (arterial) from decubitus.

The arteria innominata, it will be remembered, crosses the eighth or ninth tracheal ring.

8. Stenosis from scar tissue following ulceration (decubitus).

The after-treatment of tracheotomy is important. Secure moist air in the room to keep the secretions from drying and occluding the canula. Remove the inner canula frequently and keep it clean. On the third day remove the outer canula, and see if the patient can breathe without it. If not, reintroduce, but use another canula. This renders less the danger of decubitus. After two more days remove again, and if necessary to reintroduce, use the first canula again. Do not remove the canula the first time before the third day. The wound heals rapidly, and by so doing a second operation might be necessitated. Be sure the wound is large enough to admit the canula without undue pressure, but don't go low enough to endanger the arteria innominata. In Vienna we were strongly advised in all cases to make intubation before commencing

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a tracheotomy. It prevents stenosis from retraction of the head, and gives the operator more time, thus enabling him to operate more deliberately.

A few words as to the method of making an intubation may not be inappropriate.

The patient should be held in the upright position in the lap of the nurse. Let the child's legs be held between the nurse's knees. Let the arms of the nightshirt be slipped down over the hands of the patient, and held in the nurse's right hand, while she puts her left arm around the shoulders of the child, thus holding him firmly against her chest. Another assistant should stand behind to support the patient's head in an erect position with his right hand, while his left holds the mouth gag. If the patient is very weak, the tube can be introduced with the patient prone, having his head thrown slightly backward.

The patient being held in the manner described, with the mouth gag in position, the operator passes his left forefinger along the base of the tongue till he feels the posterior surface of the larynx. Then he withdraws it slightly until the tip rests upon the right edge of the larynx. Keeping it in this position he presses the epiglottis firmly against the base of the tongue. Now, with the finger as a guide, the tube is gently and rapidly slipped along it, keeping it exactly in the middle line and pressed against the side of the finger. As the point passes backward, the handle is raised to secure its entrance into the larynx.

The accidents to be avoided are these:

If you do not keep the epiglottis pressed well forward, the point of the tube is liable to slip into the fossa between it and the base of the tongue. If you do not keep it directly in the median line, it is apt to pass into the esophagus at the side of the larynx, or if you do not follow carefully the side of the finger as a guide, or if you do not raise the handle sufficiently and at the right instant, it may pass posteriorly into the esophagus. When the canula has entered the larynx and been pressed down very gently as far as it will easily go, the intubator is to be rapidly withdrawn and at the same time the canula is to be pressed still farther downward and forward against the base of the epiglottis with the tip of the finger.

At this step in the proceeding there are several precautions to be observed. Be careful not to twist the canula and to keep it in the axis of the larynx. Do not press it sideways or posteriorly and do not press it against the intubator. In withdrawing the intubator, keep it also in the axis of the larynx. To do so it must be raised first, directly upward and not forward, until it is disengaged, and the handle must be kept strictly in the middle line. If these points are not carefully observed, the intubator will stick in the canula and the latter be

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displaced. Dexterity, rapidity and delicacy of touch are of prime importance in making the operation. The thread attached to the canula should be drawn between two of the upper teeth and fastened to the cheek, and the patient's hands should be bandaged so that he cannot displace it.

The length of time the canula should be allowed to remain is another point. Eighty hours is said to be the maximum limit. I do not mean eighty hours continuously, but eighty hours in the aggregate. At first it should not be worn more than twenty-four hours without removal. Wait a few hours before reintroducing it. The second time it should be removed after eighteen hours. When the use of the tube cannot be discontinued after the aggregate length of time it has been worn amounts to eighty hours, it is better to make tracheotomy rather than to incur the risk of ulceration and necrosis by longer use of it.

The prognosis of intubation is said to be better than that of tracheotomy during the first year of life. With the latter there is more danger of pneumonia at this early age than later in life. The prognosis is less favorable when the temperature is high, and it is also bad when the false membrane is loose and vibratory because of the liability of occlusion of the tube, and also when the pharynx and nares are occluded with membrane or swollen tonsils.

In making tracheotomy, care should be taken to make the incision exactly in the median line. The muscles should be separated with a probe or with the handle of the scalpel, and the isthmus of the thyroid raised and held out of the way by an assistant and the tracheal rings incised (2 or 3) from below upwards. An intubation set should be on hand for immediate use, inasmuch as the retraction of the head necessary for performing the operation is apt to produce asphyxia, as has been already mentioned. For this reason the introduction of the laryngeal canula is often a desirable preliminary measure.

Discussion:

Thomas M. Stewart, M. D.: One of the most important things in connection with intubation, is the biting off of the extracting thread, so the attendant would not be able to extract in case of necessity. This can be avoided by plugging the teeth with a dental plug, and in that way the thread can be brought between the teeth and held there until the removal of the plug. Regarding the use of an anesthetic in tracheotomy, in cases where an anesthetic is contra-indicated, ethyl-chloride can be used to advantage, or the Schleich method.

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IRREGULAR PRACTITIONERS OF OPHTHALMOLOGY

D. A. MacLachlan, M. D.
DETROIT, MICH.

For the last quarter of a century there has been in discussion, pro and con, medical laws intended to do away with quacks and charlatans, who were numerous everywhere, particularly in the cities. Titles were easy; almost any man might call himself Professor or Doctor. The barber, the dancing master, the clairvoyant, etc., dubbed himself "Professor." The quack, the patent medicine vender the optician, etc., styled himself "Doctor;" and for many years men hesitated to be called by the title lest it might confer opprobrium rather than honor. The question of a medical law was a matter of constant discussion in medical societies and journals, and in the public press. The writer was among those in earlier years to discuss the subject editorially, and then, as now, favored supervision and regulation of medical colleges by a State Board of Registration, instead of examination of medical graduates by a State Medical Examining Board. The latter, even then, was the system in vogue in Canada, if not in more or less of our own States. The work of the state medical law in Canada was not such as to encourage the medical profession of our own country to adopt a similar one.

More or less attempts were made in my own State to get such a law passed by the State Legislature, but Michigan was very tardy in the matter, and for a long time was termed "the dumping-ground for the United States;" in other words, many of the older states had already adopted medical laws driving quacks and irregular practitioners over the borders and into our own state. Finally the Legislature of '95 was persuaded to consider and pass a medical law which its promoters intended to be a registration and licensing law, establishing a board to license and register all graduates of recognized medical colleges. However, those in charge of the bill took the liberty of so wording it as to make the board a body to examine and license any and all who chose to apply, except graduates of medical colleges in Michigan, and of certain outside colleges which the board designated. There is not time, even if it were profitable to mention the features of the medical laws now existing in most of our states. Perhaps that of Michigan, being one of the latest, is a fair type, embodying most of the salient features of all.

The Michigan law first establishes a Board of Registration in Medicine, composed of ten physicians, appointed by the Governor, "of whom not more than five shall be allopaths, two homœopaths, two eclectric and

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one physio-medical." This was intended to give the principal schools of medicine representation, and to prevent the dominant members from practically excluding the others. They are appointed in two classes of five each—one class to serve two years, the other four years. "All business shall be transacted by and receive the concurrent vote from at least seven members. Seven is a quorum. Two regular meetings are held annually, in June and October.

Applicants for license to practice must be 21 years of age, and of good moral character. They are divided into five classes:

1. Those registered under the law of 1883, who are to be given a certificate if applied for within six months after the act took effect in October, 1899, upon the payment of *One Dollar.*

2. Those registered in a foreign country, the requirements in which are equivalent to those of Michigan, provided such country shall accord a like privilege to holders of certificates from the Michigan Board, on payment of *Twenty-five Dollars.*

3. Those who pass an examination before the board upon the following subjects: Anatomy, physiology, chemistry, pathology, therapeutics, toxicology, histology, hygiene, public health, laws of Michigan, practice of medicine, surgery, obstetrics, gynecology, diseases of the eye and ear, bacteriology and medical jurisprudence; on payment of *Ten Dollars.*

4. Those licensed by another State Board, in which the requirements are equivalent, and which accords a like privilege to holders of Michigan certificates. The fee for such to be *Ten Dollars.*

5. Those holding a diploma from any legal medical college in Michigan, having a three years' course of eight months, or a four years' course of six months, or, from such colleges outside as shall be approved and designated by the board, on payment of *Ten Dollars,* without examination.

"When any person shall append the letters M. B. or M. D., or prefix the title 'Dr.' or Doctor, or any other sign or appellation in a medical sense to his name, it shall be prima facie evidence of practicing medicine and surgery within the meaning of the act." Such person shall be deemed guilty of a misdemeanor, and on conviction shall be fined not more than $100.00, or be imprisoned not more than 90 days, or both. Violators of the act are to be prosecuted by the prosecuting attorney of the county, on information from the county clerk, a member or members of the board, or any person entitled to credit. The usual exemptions are made for commissioned surgeons of the army, navy, and marine hospital service, for consultants, dentists, temporary emergencies, domestic practice, and osteopaths. Medical students are allowed to practice only as assistants under the direction of their preceptors who are made responsible for their professional conduct and acts.

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A unique feature of the Michigan law is the clause exempting "legally qualified osteopaths engaged in the practice of osteopathy" whatever that is. It came about through a special act passed in 1897, licensing osteopaths, and exempting them from everything exacted from others. Just why the law should discriminate in favor of one class of persons in this way is hard to see. It seems like class legislation and therefore unconstitutional. I only mention it to call attention to the invidious distinctions and imperfections that exist in the present State Medical laws, for Michigan is no exception in this respect. Similar inconsistencies are to be found in most, if not all, of them. The great majority are full of injustice and unnecessary hardships to both medical students and practitioners, and wofully fail in accomplishing what they are intended to do.

Was not the primary object to weed out quacks and unqualified practitioners, and to prevent other would-be charlatans from entering the field of legitimate practice, rather than to obstruct and burden the honest and earnest student and the graduated and qualified practitioner of medicine? As far as my observation has gone, the principal efforts of the examining boards have been directed to making the pathway of those who really desire to fit themselves for the legitimate and intelligent practice of medicine and surgery as thorny and rocky as possible, both before and after their graduation, while the blatant quack, the illegal and unqualified practitioner, has begun or continued his deplorable and often nefarious work upon the indiscriminating and innocent people, with little or no hindrance.

The elevating of the standard of medical education in our country has certainly kept pace with that of other branches of education during the past twenty years. With the habit of the American people to go forward by leaps and bounds, members of our profession too often assume that something different is something better, forgetting the injunction of holy writ to "hold fast that which is good." The marvelous development of our nation and country has demanded constant and large accessions to the ranks of the medical profession, and the addition of 2,000,000 immigrants annually, together with the normal birthrate among 75,000,000 of people already here, and the millions being added in the Philippines, Hawaii and Porto Rico, will still require large accessions for years to come. All we need is better, broader, and more practical education of medical students in the future. We do not need to load down the student with restrictions, hardships, and expense, but to give him a better preparation and better facilities for study, and, better outfit and better fees in practice.

I have nothing in common with the doctor who can see nothing but self-aggrandisement and mercenary motives in those of his fellows who

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undertake to instruct students in the science and art of medicine, and to create in their minds lofty ideals of the character and dignity of our noble profession. The practice of medicine is not merely a business by which to gain a livelihood, but a work of mercy and humanity, of devotion and self-sacrifice, for which *but few*, comparatively, are fitted, and for which education alone cannot qualify anyone. In what other profession or business can you find men and women devoting much of the best years of their lives, at infinite personal sacrifice of pleasure and time, to didactic and practical instruction in lecture room, laboratory, and clinic, with no other fee or reward than that which comes to the traveler who in chafing the limbs of his freezing comrade finds the blood warmed in his own veins? How many of us, as we look back upon the ambitions and struggles of our student days, fail to remember the kindness, the encouraging words, the sympathy, and ofttimes the material help we received from our old teachers. Most of them have passed over the river, but their lives will be ever kept green in our memory, and who shall dare to traduce them by saying they were not fit to practice the medical knowledge of their times, or that they were not honorable or not to be trusted with the graduation of students?

There are those in our day, however, who assert that the medical teachers of to-day are neither capable nor honorable enough to say, after years of association with him, whether a student is qualified or fitted for the practice of medicine. No, they say, he should be examined and passed upon by men who never saw him before, who never taught, and have no judgment as to what a student should know, who are not experts in anything, least of all in the subjects they examine upon, and who owe their appointments to their devotion to ward or county politics, instead of their devotion to science and humanity. After four years of hard study and work in lecture room, laboratory, and hospital, and after being pronounced worthy by those who know him physically, morally and intellectually, from personal contact, he is taxed ten or more dollars, several days' time, railway and hotel expenses, to be licensed or not licensed to practice, according as he succeeds or fails to answer a long list of questions culled from some old, obsolete text-book, and having little, if any, relevancy to the work he has done or is about to do. Even after he passes such a board, if he wishes to practice across the lines in another state, he must go through the same useless and insulting travesty of what should be a dignified, intelligent and judicial proceeding. How does crossing the border change him? There is as much sense, however, in subjecting him to this third inquisition, after he had passed the first State Medical Examining Board, as in having to go before a State Board after having taken the work and examination required by a familiar, learned, critical and conscientious college faculty.

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There can be no objection to a state board of impartial, honorable and earnest men to examine the diplomas of persons entering the field either from college, or practice in another state, and to license them, providing their credentials are from a recognized and reputable institution, and to prosecute and drive out all persons who attempt to practice medicine without such qualifications. But anything further than this is an unwarranted interference with the constitutional rights of the citizen and an insult to the college faculty authorized and empowered by the State to grant degrees entitling holders to practice their profession. If State Medical Boards would only perform the chief duty for which they were created, the prosecution and suppression of illegal practitioners, they might be of real service to the profession and the people at large. And this brings me to the real subject of my paper, "Irregular Practitioners of Ophthalmology."

Within the last few years, what are termed schools or colleges of ophthalmology have sprung up in nearly if not quite every state in the Union. These profess to teach the correction of errors of refraction, eyestrain, and eye diseases, and to make men in effect physicians and surgeons. The persons who enter these institutions come from all classes and conditions of men. Not long since a former minister whom I had known called upon me, and asked to be allowed to take a special course in the Detroit Homœopathic College, upon diseases of the eye. He led up to it by saying, "Well, doctor, you'd hardly guess what I am doing now." He added, "I'm practicing opthamology—I graduated from —— College of Opthamology (naming a place in our city that I had seen advertised as run by a man using the title M. D., and Oculist, but who indulged in various practices, ethical and unethical, with a not very savory reputation), got a case of lenses, advertised dates in towns and villages of the State, and you ought to see the crowds that greet the distinguished oculist from the metropolis." Intelligent as he is, he did not try to assume that either of us could fail to see the absurdity or shadiness of the situation, so he treated it as a joke. He seemed surprised, however, when I told him he could only get such instruction in the D. H. C., by taking the regular work of the first three years and studying opthalmology in the fourth year.

This is only one of thousands of such instances throughout the land only most of them haven't the intelligence or the literary qualifications possessed by the ex-minister opthalmologist.

Not long since I was "called down" by a man who took exception to some remarks I made concerning spectacle fakirs. He gravely informed me he is an "opthalmologist, not a mere oculist," throwing considerable disdain into his tone in pronouncing the word "oculist." "He not only studied diseases of the eye, but how to make and fit glasses, and

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examine and diagnose other things as well." He claimed to know that diagnosis and treatment of ocular disorders are not taught in medical colleges, because he graduated from Pulte College twenty years ago, and knew whereof he spoke. Inasmuch as he is a very intelligent and honorable man, and through his occupation well known by and in constant touch with medical men all over the country, I did not try to show him the error of his ways, but contented myself with telling him he was mistaken.

In most instances the persons turned out from these so-called schools call themselves or are properly dubbed "Doctors ——," and undertake to perform the functions of a real doctor. Inasmuch as they are out "for what there is in it" commercially, and are not handicapped by any such money bugaboo as a code of ethics, they corral the unwary patients by the drove. They go about the country first exciting the fears of their victims, then wheedling them out of their dollars by the familiar methods of the charlatan. Certainly every one present knows full well the character of most of these individuals, and the kind of work they are doing among the laity. Their business is to sell glasses, and sell them they will if they can, by hook or by crook, and whether the patient is made better or worse by wearing them. Some of them doubtless are honest and good intentioned, but under woful misconception and misapprehension of an oculist's calling. But many of them neither know nor care what commercial, physical or moral wrong they do their deluded patrons, so long as they reap the harvest of shekels the managers of the so-called optical schools have taught them to hunt for and to find.

I need hardly enumerate in your hearing the various injuries suffered by people at their hands. You have too often been called to do something for the eyes after the so-called "Doctor" had fitted several pairs of convex glasses of increasing strength, each pair aggravating the condition, and your heart has been wrung with pity as you recognized glaucoma and had to tell the poor patient he was hopelessly blind; or, one promised a cure by glasses, later blinded by optic nerve disease; or a patient told to wait for a cataract to ripen, blinded by glaucoma; or one half-blinded by strong convex glasses, when weaker ones or cylinders were needed; or eyes strained by concave lenses, given for astigmatism or amblyopia; and so on, *ad finitum*. You have seen these and other cases time and again, and need only to recall them to realize the need for something to check the evil, growing like Jonah's gourd.

Another important incentive for such action is the usurpation of the physician's rights and functions by these men. What more right or reason have they to presume to treat patient's eyes, without taking the regular course of study in and a degree from a medical college, than have others to presume to treat other diseases without a diploma? Why

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should not persons who essay to treat eyes be compelled to study and graduate in medicine, just the same as one who essays to treat lungs, or fits, or worms, or appendicitis? It appears to be entirely logical and reasonable that they should.

Again, to look at another side of the question, why should not medical men throughout the country unite, as do other classes of citizens, in protecting not only their medical interests, but the dignity and prestige of their profession? It is notorious that men with neither natural nor acquired fitness or qualifications for the practice of medicine in any or all of its departments, seek to enter the field out of purely commercial motives. Such men lower the tone, lessen the prestige, and bring into disrepute a noble and learned calling. This in itself is enough to lead the legitimate members of our profession to put forth their utmost efforts to weed out these intruders, and to make it impossible for them to again encroach upon our territory.

This lowering of our professional standing is not the only evil. Our medical interests, which we, with every other citizen, have a right to protect and defend, are greatly injured. Every man is entitled to a legitimate remuneration for services rendered to persons who are able to pay. To those not able to pay, the worthy poor, the physician in all ages has rendered capable and willing aid without fee or reward, and I am sure we would all regard it as a calamity to ourselves, as well as to humanity at large, if this philanthropic feature of our professional calling were to lessen or cease.

It being conceded that a large portion of the physician's work must be gratuitous, it follows that others who are in position to properly remunerate him should do so gladly and generously, else how can the physician exist and be properly prepared to render efficient service. He must not only have the means of subsistence, but the necessary books, medicines, instruments and apparatus required to practice his calling in this advanced age.

It seems needful, then, for the physicians throughout the country, as well as in states and localities, to associate themselves together for the purpose of mutual protection in the matter of service and fees, and to protect themselves from being imposed upon by those who demand his services and refuse to pay his legitimate charge. Just so long as medical charlatans and fakes are permitted to crowd the field and impose upon, not only the people, but the medical profession as well, just so long will legitimate members of the profession suffer in both standing and income. So long as any department of medicine is allowed to be thus invaded, just so long will it be impossible to prevent the same thing extending to other departments. It is well to remember the traditional story of the Arab and the camel. The camel begged to be permitted to

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merely put his nose inside the tent out of the cold and storm, but no sooner did he gain access to the tent than he very soon wriggled his whole body inside. If the medical profession allows this undesirable class to enter the field of legitimate practice, the whole body will soon be wriggled inside, crowding out and injuring the rightful possessors.

I believe you will agree with me that it is high time that new organizations or those already existing should enter upon a systematic crusade to drive out and keep out, not only the irregular practitioners of ophthalmology, but those of every department of medical practice, and that this must result in elevating the tone and standing of medicine in every community and bring to the individual practitioner a legitimate reward for his tremendous outlay of time and money in preparation, and of sacrifice, study and toil in the pursuit of his calling.

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ORTHOPEDICS FROM THE STANDPOINT OF THE GENERAL PRACTITIONER
C. E. SAWYER, M. D.

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RENAL ENGORGEMENT.....W. S. BRIGGS, M. D.

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ORTHOPEDICS FROM THE GENERAL PRACTITIONER'S STANDPOINT

C. E. SAWYER, M. D.
MARION, O.

INTRODUCTION:

To the average general practitioner there comes no more trying subject than orthopedics. There is nothing in the category of diseases to which his attention is called that may terminate so disastrously to the welfare of the patient and the reputation of the physician as do the cases that fall within the domain of this important branch of surgery.

As distortions and deformities and the inconvenience they bring are a handicap to every life, it is well that great importance be attached to their prevention and removal whenever and wherever possible. There is no field in surgery in which so much depends upon the general practitioner, for it is he who meets the orthopedic case first. He sees it in its inception, and as it is at this time that the greatest good can be done it is all-important that advice be properly given and correct methods instituted.

The number of disorders which fall within the jurisdiction of orthopedics are too great to be considered here; furthermore, there are many orthopedic cases which are so rare as to be of interest only to the specialist. The majority of cases which come to the general practitioner fall within the realm of a few conditions which are quite common, and in order that all elements of specialism may be eliminated from this paper and that fundamental principles may be emphasized, I shall confine myself to the consideration of such cases as are most frequently met with and are most amenable to the general practitioner's forms of treatment.

DISEASES CONSIDERED.

The list presented will, therefore, consist of joint-diseases, spinal curvatures, and club-feet, which constitute about ninety-five per cent of all ordinary orthopedic cases. It will not be possible to enter into a teratological discussion of any of these subjects, but it shall be my endeavor to treat each of them in a practical manner.

Orthopedic disorders not only endanger the usefulness of the body, and impair the general health, but they oftentimes leave the subject of their invasion crippled for life, if they do not, as they may, jeopardize life itself. They are usually most insidious in their onset and extremely misleading in their early manifestations, and yet it is in their incepton that treatment is most useful; therefore, the necessity for extraordinary vigilance in their early recognition, and the great importance of the gen-

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eral practitioner's knowledge of the means to be employed which will be adequate to their relief. It is always better to be over-zealous in anticipating disastrous consequences than to be betrayed into doing nothing by carelessness, or, what is still worse, by being content in the belief that time will afford relief to threatening appearances.

In the matter of examination in orthopedic cases it is the duty of the general practitioner to look thoroughly into the history of each individual case, and to search with scrutinizing care into the real cause that produces the symptoms presenting, for, although they may be transitory in character, and subside quickly, they should not be discredited.

REMINDERS.

I would remind you that in orthopedic diseases the pain is often referred to other parts of the body than that directly affected. I would also remind you that the distress is often vague in character and not infrequently taken to be the result of rheumatism, growing-pains, or kindred disturbances which are really in no way connected with the trouble at hand.

I would also remind you that there are but few subjective symptoms to guide in early diagnosis; therefore, whenever there are evidences of general constitutional disturbances, even where local manifestations are not marked, suspicion should be at once directed to some deep-seated disorder.

This being true of orthopedic disturbances in general, it is highly important that we appreciate the necessity of early recognition; correct diagnosis; concomitant conditions, and means and methods of early treatment.

EARLY RECOGNITION.

In order that we may not be misled in early recognition, it is especially needful that we investigate thoroughly the history of each case, ever remembering that the most disastrous consequences may hinge upon slight etiological factors, and that oversight of small things may lead to irreparable conditions.

Ordinarily the pain complained of in orthopedic diseases is at first transitory, and relieved upon exercise or by rest, and the pain which accompanies is almost invariably referred to some other part of the body. Thus, in hip-joint disease, we find the patient complaining of pain in the knee. In spinal curvatures the distress is altogether in the limbs, while in other common forms of joint-disease it is so widespread in its manifestations as to be readily mistaken for other conditions than the real one, and if these matters are not all taken carefully into consideration, a disorder which would be most amenable to treatment and quickly cured lapses into one of serious consequences with extreme destructive tendencies.

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DIAGNOSIS.

In the matter of diagnosis none of the disorders with which we are familiar affords a more striking example of the necessity of care than does hip-joint disease as compared with knee-joint disease. In the former it is well to bear in mind that the pain complained of extends over a considerable surface, affecting more especially the anterior and internal aspects of the joint, while in knee-joint disease the pain is more circumscribed in its location, more defined in its sensitiveness to contact, and less spasmodic in character.

Add to the foregoing signs the history of loss of motion and muscular atrophy, there need no longer be doubt as to the true nature of the trouble, especially if supplemented by night-cries.

SUBJECTIVE SYMPTOMS.

Hip-Joint Disease.—Presuming that we have the symptoms above presented, *viz.*, transitory lameness, vague aching pains, pain in the knee and night-cries, it is our duty to investigate thoroughly all objective symptoms as well, and to further demonstrate the importance of care in investigation in joint diseases we will proceed with the findings in a case of hip-joint disease, because in hip-joint diseases we have a perfect exemplification of the needs in all joint diseases.

With the body stripped of all clothing, it will be found that while standing the patient makes a solid column of the sound side, avoiding all weight and concussion to the affected one. The affected limb is slightly flexed at the knee and rotated outward, the gluteal muscles and the muscles of the back of the affected side are relaxed, while those of the opposite side are more than ordinarily rigid; the gluteo-femoral crease is shallower than on the opposite side, and there is a slight drooping of the buttock on the affected side, with some loss of contour. All manipulations tending to change the relation of the parts, such as forcible abduction, adduction and rotation, are all more or less affected by the muscular rigidity present, which causes fixation and inactivity of the joint.

I have gone into minute details in the findings of hip-joint disease to emphasize the importance of care in examination and diagnosis in all joint diseases, for the findings in other joint diseases are no less marked than in hip-joint disease, and if the general practitioner will only take time to investigate properly he will find sufficient evidence in every case to enable him to render reasonable and favorable judgment, and thereby preclude disastrous consequences which are sure to result from less vigilence.

Spinal Curvature.—As we are dealing with diagnostic factors it may be well to pass in review the symptoms of spinal curvature, as they most commonly present, in order that we may surely be able to recognize this

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class of cases early in their onset, for here, as in all other orthopedic diseases, early recognition is of great importance.

Pain is almost invariably present as an early symptom. It may be lancinating, or dull and aching in character, and may be described by the sufferer as occurring in various parts of the body, in the feet and lower limbs as well as in the trunk. Many times this important symptom is overlooked. These are the cases which are said to be rheumatic, or the mother is led to believe that they are "growing-pains," and because of the child's seeming indifference to occupation it is oftentimes thought to be lazy and indolent, seeking sympathy.

Again, we find loss of appetite, languor, indisposition to play, troubled sleep, smothering sensations, sighing respiration, hacking cough, palpitation, constipated bowels, frequent urination, enuresis, and various other reflex manifestations. These constitute the most characteristic subjective symptoms, and some or all of them are invariably present in the premonitory stages of spinal curvature, and if they are considered in connection with the objective symptoms, which will develop from a careful examination, they will be found sufficient to clear up the diagnosis and prevent the disaster that must result from their being overlooked. When one or more of them are found in any case recurring frequently or continuing persistently it is the imperative duty of the physician to strip the child and determine their significance.

OBJECTIVE SYMPTOMS.

The prominent objective symptoms will depend somewhat, of course, upon the form of curvature, but as I am dealing with generalties I will give the leading ones occurring in the various forms of curvature.

Among the physiological factors it will be noticed that the child falls often, and upon arising from a stooping posture comes up slowly, supporting itself with its hands on its knees; it walks with more caution, and if it attempts to pick up an object it will extend the arm down the side rather than stoop to pick it up; the feet slide upon the floor, the elbows are thrown back, the head is inclined backward, forward or to one side, the abdomen protrudes more than normal, the chest is higher on one side than the other, one shoulder will be found in advance of its fellow, the body inclines to one side, the thoracic wall markedly concave on one side, and more than ordinarily convex on the opposite, the face is pinched and distressed, the patient is fretful and nervous, becoming tired and cross and sometimes vengeful in its disposition. One hip will also be found enlarged, one shoulder-blade protruding, and if in a boy one limb will be found invariably longer than its fellow, and its size will not be uniform, as compared with the opposite one. If a case of Pott's disease, a small lump or protrusion will be found somewhere along the vertebral column. To be sure, many of these manifestations may be absent. Espe-

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cially will this be true early in the history of the case, but a careful weighing of such as do present will aid in a correct diagnosis.

Other important factors to be taken in evidence are family history. age, sex, and general surroundings, always bearing in mind that about nine-tenths of the cases occur in girls, most frequently between nine and sixteen years of age, and that all spheres of life are subject to the disorder. This latter opinion may be at variance somewhat with some of the text-books on general surgery, but investigation will show that they are about equal in proportion in the families of the poor and the rich. This need not be true, for, as it is a condition of mal-nutrition, the better classes might be exempt were they more careful in their habits, but mal-nutrition is the same, whether it comes from a lack of needed material or by the abuse of that which we have.

Club Feet.—In the foregoing disorders, joint diseases and spinal curvatures, there is some excuse for oversight or lack of full appreciation of the conditions to the extent of want of careful diagnosis, but club-feet are so apparent that there can be no justification for lack of early recognition and the early beginning of treatment. Yet, oftentimes these cases are allowed to go on until they have passed to a stage of incurability, and in order that we may be able to meet the demands of this large number of afflicted individuals it is well that we familiarize ourselves with the obstacles to their recovery. Among the greatest of these is a disposition on the part of the general practitioner to defer treatment. The commonest answer given in cases of club-feet to the interrogation "Why did you not begin the treatment of this trouble earlier?" is, "Our family doctor advised us to wait, saying that the trouble might be outgrown, or at least that there was no necessity to give the matter special attention unil it was time for the child to walk"—advice as irrational as it is dangerous.

Every hour a case of talipes grows older, it grows stronger, and the difficulties in cure become more and more augmented, and for that reason the general practitioner should be impressed with his duty in this class of cases. I believe that the time is near at hand when any doctor who allows a case of club-feet to go untreated will be held criminally liable, for there is absolutely no reason why all ordinary cases of club-feet should not be cured in infancy, and that, too, by means which are within the reach of every general practitioner in the country. So far we have only considered the necessity of early recognition and the importance of care in diagnosis.

CONCOMITANT CONDITIONS.

If we have been sufficiently careful in these we are in position to weigh concomitant conditions, study anatomical relations, and apply means of cure. In all cases of orthopedic disease we should ever bear in mind that much of the trouble may depend upon reflex conditions.

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A significant fact is that in a large percentage of all boys afflicted with orthopedic disease, there is phimosis, while in girls there is an adherent hood of the clitoris. To such as have never given this subject much thought this might be regarded as an orificial fad, but statistics prove with unerring certainty that there is a co-existing relation between these parts and orthopedic disturbances. Conjoining these facts with a strumous diathesis, a history of injury, and the age of the individual, and we have concomitant conditions and physiological factors sufficient to the establishment of a proper diagnosis.

ANATOMICAL RELATIONS.

To place in perfect operation any part that has become "out of gear" we must consider its normal operation. We all know that joints are very complicated in their construction, and that their relation to the human body is very important; therefore, we must consider the muscles that operate them, the synovial membrane that keeps them oiled, and the articular surfaces that are engaged in their operation. We must also bear in mind that the bony relations are intimate, the nerve-supply complicated, the vascular supply intricate, the variety of movements numerous, and that the exactness with which its component parts are bound together preclude any infringement of foreign substance without danger to its integrity.

In the matter of spinal curvature we should bear in mind that the spinal column in its entirety constitutes one of the greatest pieces of mechanism nature has produced. Controlled as it is by both voluntary and involuntary forces, the maintenance of the body's center of gravity must depend upon perfect muscular development and normal anatomical relations; when the muscular system, from lack of natural food-supply, proper exercise, or faulty position, becomes wanting in tone or enfeebled in action, the consequent result is that the muscles pull harder on one side of the body than the other, and at once bring about a disturbance in the normal relation of the osseous parts. Soon, from irregular pressure, the bones become changed in their normal position, and it is but a short time until a curvature becomes manifest.

In club-feet we should bear in mind the influence of relaxed and contracted tendons, and the necessity of beginning treatment while the bones are largely cartilaginous, and therefore easily moulded into position, and that all of the ligaments and deep fascia are at this time most responsive to means of correction and the nerves most susceptible to rejuvenation, and that each of these anatomical parts is concerned in every case, and must be looked after in the bringing about of perfect cure.

TREATMENT IN JOINT DISEASES.

We must also bear in mind that with any disturbance of normal

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relation there begins irregular muscular action which forces the parts into unfavorable relation to each other, thereby producing the perpetuating cause of most distortions, the complete counteraction of which is essential to the successful treatment of any orthopedic disturbance; therefore, one of the first conditions to be met in the treatment of joint disease is to overcome the influence of this abnormal relation. To do this, proper arrangements must be made for the execution of the following cardinal principles: (a) Absolute physiological rest; (b) extension; (c) employment of proper antiphlogistic remedies, and (d) due regard for constitutional requirements in matter of hygiene, sanitation and dietetics. Of these, none is more important than rest, and if the general practitioner can do nothing more he can at least advise means of immobilization and quiet of the part affected. This does not necessitate extensive and complicated apparatus, neither does it entail confinement to bed.

Ordinarily, if cases are recognized early, even though the joint affected be one of the lower extremities, all that is required is to put the patient on crutches and take all pressure off the affected part until it has ceased to be painful. This may require but a few days or it may require several weeks, and even months, but, be this as it may, the patient or the friends in charge should be impressed with the absolute necessities of the treatment.

It will not do to compromise in these important matters, for to do so is to jeopardize the use of the joints. Aside from the matter of absolute rest of the afflicted part, it will oftentimes be necessary to make some extension. With a little practical ingenuity on the part of the doctor the demands in this way can also be readily supplied. If it is an ankle, a knee or hip that is affected, with a high shoe on the sound foot, a piece of adhesive-plaster and a slight weight attached to the lame one, by the use of crutches it can go on to rapid recovery.

To overcome heat, pain and swelling, which are often early accompaniments of joint diseases, nothing meets the demand better than ice-bags constantly applied, with the indicated remedy.

With these few simple contrivances, with care in diet, hygenic surroundings, and proper sanitary conditions, a few weeks will usually suffice to cut short any joint disease. The great interference with a favorable outcome of such cases is the failure of the physician to impress upon those concerned the importance of persistence in the use of the means employed.

Every possible effort should be made to induce patients to be extremely careful as to the use of the affected part, and especially as to the dangers which may arise if proper requirements are not fulfilled.

With these few suggestions, well carried out, and the homœopathically indicated remedy, timely and properly administered, much of the

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suffering and deformity of joint diseases will be overcome, and much in the way of justifiable criticism may be averted.

SPINAL CURVITURE.—TREATMENT.

In the treatment of spinal curvatures we are confronted with more exactions, more liabilities, and greater demands, for here we have troubles which are not only local, but constitutional. Disorders of this kind require mechanical contrivances more or less intricate in their constructions, but still they may all be so simple as to be made by any blacksmith and trimmed by any housewife. Therefore, there need be no excuse whatever for the use of the plaster-jacket, which, in most cases, is worse than no treatment at all.

In connection with the employment of apparatus in all forms of spinal curvatures, it is agreed by all orthopedists that physical-culture treatments stand pre-eminent in the matter of cure, and, ranking first of all, are correct habits of breathing, standing, sitting and walking erectly. In many cases it is a difficult matter indeed to train the patient to execute these orders, but as nothing but continued effort will accomplish the desired end, and as the object sought is so worthy, the importance of the subject should be impressed upon every one related to or associated with the patient.

These directions, no matter how well executed, are not sufficient in themselves to overcome the trouble, and certain special movements are always to be ordered. These consist of trunk-rotation, side-extension, hip-bending, chest-expansion and head rotation, to be given in series and with systematic regularity.

MECHANICAL SUPPORTS.

From a local standpoint there is one important condition to be met, *viz.*, overcoming of distortion by some means which will serve to hold

PLATE No. 1.

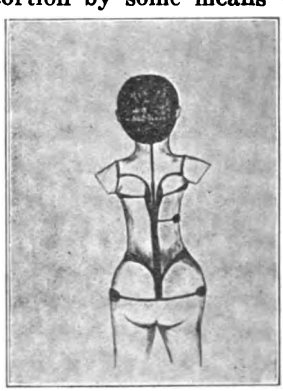

PLATE No. 2.

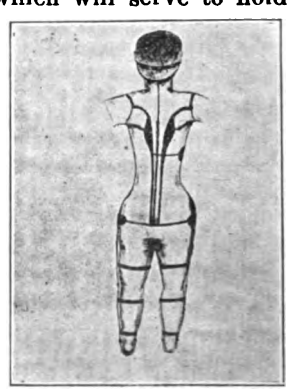

PLATE No. 3.

the part as nearly as possible in a natural position. This is best accomplished in lateral curvatures by the apparatus shown in Plate No. 1, and in Pott's Disease, in Plate No. 2.

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In lateral curvature the device must be so constructed as to press the protruding scapula forward, to lift the drooping shoulder, to hold in position the bulging side, and to overcome the rotation. These points are met by the large pad over the shoulder, by the crutch under the drooping arm, by the restraining-pad on the bulging side, and by the adhesive-plaster on the rotated side.

In Pott's disease the apparatus has to be constructed differently, depending upon the location of the trouble, but always to be of such shape and form as to carry the weight of the body above the diseased joint or joints. If the affection is in the lower dorsal or lumbar region, nothing but limb-braces attached to a body-brace, with a head-support, will answer, as illustrated in Plate A. If it is above this region, hip-support may be all that is necessary, as shown in Plate B. You will note that these appliances are so constructed as to admit of very great freedom of motion of the head, and are very readily changed from time to time to meet the demands of the case. Again, they are simple in construction, easy of application, and the patient is always in position to be examined carefully and thoroughly at any time, and as children accommodate themselves to them very readily, they surely are self-commendatory, and are to be recommended in any case where a support is needed.

CLUB FEET.—TREATMENT.

The means of treatment to be employed in club-feet may be divided into manipulative, electrical, operative and mechanical. The former consists of daily rubbings and manipulations in the direction of correction. Electricity is only an adjunct, and is of little importance save as it is combined with the other forms of treatment. Upon operative treatment depends the greatest good. A simple subcutaneous tenotomy and a forceful replacement will give the most favorable returns in the shortest time of any means that can be employed. Many general practitioners are inclined to be indifferent to this mode of procedure, because they think it belongs to the surgeon, or because lay friends of the patient have advised them against it. Neither of these excuses are sufficient either legally or otherwise to relieve the general practitioner of his responsibility for they are so simple in their doing that any physician who knows the importance of clean hands and clean instruments may do the work. My rule is in any case of club-feet at any time in life, to divide subcutaneously all tendons and fascia which are inclined to keep up distortion, and after the operation to put the parts in an over-corrected position before applying mechanical means.

MECHANICAL APPLIANCES.

Club-Feet.—In the matter of mechanical appliances in the treatment of club-feet there are many perplexities, but if these three rules

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be followed there need be no great difficulty in accomplishing cure. *First,* let it be remembered that no case of club-feet should be allowed to stand on the members so long as they are out of position. *Second,* that over-correction is an absolute necessity, and *third,* that no time-limit should be placed on the wearing of any apparatus, always bearing in mind that braces should not be discarded so long as there is any need of their support. In the appliances which I use I have endeavored to make them as simple in their construction as possible, and to make each brace for the individual for which it is intended. The same law of individualization is as necessary in the application of braces as in anything else in the treatment of disease.

Usually, by taking the deformed part in the hands of the operator one can determine what points of pressure are needed. With this question settled, all that is necessary is to devise some apparatus which will do permanently that which the hands can do temporarily.

The illustrations presented here are quite self-explanatory, and if any of you are sufficiently interested you can find in these drawings and descriptions such data as will make it possible for any general practitioner to supply all the needs in the way of mechanical contrivances which any club-foot case may demand.

DISCUSSION:

HUDSON D. BISHOP, M. D.: In opening the discussion of this paper I wish to emphasize what the essayist says in his introduction, that "There is no field in surgery in which so much depends upon the general practitioner, for it is he who first meets the orthopedic case." It seems to me that in general meetings of this kind this statement cannot be too forcibly made.

Orthopedic surgery of to-day occupies a field which ten years ago was not dreamed of by surgeons. Formerly its distinctive feature was the correction of deformities; now its realm is largely the *prevention* of deformities. This has been made possible by a better understanding of the predisposing and exciting causes of deformity-producing diseases, which knowledge leads to early recognition of the disease. It is, as the essayist says, the general practitioner who so often has the opportunity of seeing these cases in their incipiency, and upon him largely rests the responsibility of the future progress of the case. If he recognizes the character of the disease, deformity can be prevented, and the disease checked; if he does not, the chances are that the disease will be prolonged, and the only prognosis as regards deformity will be a guarded one.

I think that the essay is deficient in one vital point,—namely, that the essayist has not sufficiently emphasized the pathology of joint diseases. The general practitioner should always bear in mind that the pathological condition in these insidious and slowly-developing joint disturbances is tubercular, not only because such recognition will explain the symptomatology, but it will also impress him with the gravity of the case and give the keynote to the treatment.

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I endorse all that the essayist says as to diagnosis of tubercular joint disease, but I wish to call attention to one symptom which, more than all others, points to a tubercular inflammation. I refer to limitation of motion. This is the first and most important symptom in diagnosis, and if recognized will lead to early diagnosis. Nature always gives the "first aid to the injured" in the case of an injured joint whether the injury is due to a traumatism or to a germ invasion. The muscles about the joint become fixed and rigid in the effort to put the part at rest. Any limitation of motion in any joint not explained by other things should be considered as pathognomonic of tubercular joint disease. This cannot be too strongly emphasized. Nature will set her forces to work in fixing muscles long before the subjective symptom of pain, either local or reflex, or the objective symptom of altered gait, or atrophy and deformity, are present.

Just a word as to spinal curvatures. The essayist should have differentiated as to etiology, pathology and treatment between tuberculosis of the spine or Pott's disease and scoliosis. The one is an infective inflammation requiring the treatment of an inflammation, the other is the result of imperfect nutrition and improper development. The one requires rest, the other exercise.

In the treatment of tubercular joint disease I wish to confine my remarks to emphasizing what the essayist has to say about *rest* of the part. He says, "If the general practitioner can do nothing more, he can at least advise means of immobilization of the affected part." I wish to add that if he gives proper recognition to the early symptoms and thus early in the disease secures absolute rest, fixation of the joint, and protection from injury, nature will effect a cure. I cannot endorse what the essayist says about simply putting patients on crutches. It is much safer to give the patient the additional protection of a plaster splint. As to the use of apparatus, I believe that all orthopedic cases can be immobilized as well and in many cases better by means of a plaster than by the use of any brace. In the hands of a general practitioner who is not familiar with the principles and adjustment of apparatus, I am most decided in the opinion that plaster is the most satisfactory means of immobilization.

In conclusion I wish to congratulate Dr. Sawyer upon his valuable and comprehensive paper, and I feel sure that many who are here present will profit by it.

H. P. Cole, M. D.: I believe that the general profession is partly responsible, or in the future may be responsible, for all, or nearly all of the cripples that we see on the streets. You may not appreciate it, but they are very numerous. The constitution of the patient has much to do with all orthopedic work, whether tuberculosis exists or not, The vitality of the case is below "par." That is the point on which to base all of your treatment. In these joint inflammations, there is a lack of sufficient vitality, of sufficient nutrition; and it is a case of necrosis from starvation, rather than destruction from acute inflammation. In every inflamed joint, I think I can make it general, the inflammation can be arrested by the application of a roller bandage, without any other treatment. You put a roller bandage on one of these

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inflamed joints, and in twenty-four hours the pain and severity of the inflammation will be gone. Don't have it too tight. The inflammation is due to an excess of venous blood, not arterial. In regard to plaster-Paris, let me say, it is a dangerous thing to use; in twenty-four hours after it is applied it is not just as it was when it was first applied. The soft parts shrink away, and there is contact only at the ends of the bones, which will not bear contact. If a joint is healthy it will bear pressure; if it is not healthy it will not. I have not used plaster for a long time, for I have never taken a plaster cast off that I did not find bad effects from it. In regard to the use of braces, in last year's Transactions of the Institute, you will find on page 256 a long article giving my views on that subject.

H. M. Collins, M. D.: In regard to the treatment of hip-joint disease, these cases usually have deformity, and they should be put to bed and extension made in a line with the deformity, and then the limb gradually rolled until the deformity is overcome. Then will be the time when a plaster-of-Paris cast will be very useful, and also very inexpensive for poor children. In applying, begin below the umbilicus, then down the diseased leg to the knee, then elevate the foot, and the child can be permitted to be up and about on crutches. It can be left on six months or a year, until the diesease is entirely cured. I should not dare trust the ordinary way, with the risk of blows the leg might get without something to protect the joint.

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DIAGNOSIS AND TREATMENT OF INTESTINAL OBSTRUCTION

GEORGE S. COON, M. D.
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Intestinal obstruction is a subject of mutual interest to both surgeon and general practitioner, but especially so to the latter, upon whom devolves the responsibility of first recognizing the condition, for upon a correct early diagnosis, followed by rational treatment, depends the ultimate result. Only he who has stood by the bedside of a patient with acute intestinal obstruction can realize the difficulties encountered, the obscurity existing, the uncertainties arising, in arriving at a correct knowledge of the pathologic condition with which he has to deal. The mechanical and pathologic conditions which may intercept the intestinal current are so numerous, and so obscure, that the keenest diagnostic skill and widest experience are often helpless in arriving at a correct estimate of the exact state of affairs which exists.

Intestinal obstruction may be either a partial or complete arrest in the intestinal contents, and is due to dynamic or mechanical causes. The dynamic cases are frequently seen after operations, and are due to inflammation, lack of nerve force, or muscular weakness, all of which interferes with peristalsis. It is in this class of cases that surgery is of little avail, but which sometimes yields to medication. It should not be forgotten that mechanical obstruction in time causes paralysis of the bowel, and consequently a dynamic obstruction often remains after a mechanical obstruction is relieved.

Clinically and for very practical reasons, intestinal obstruction is classified as either acute or chronic. Chronic obstruction is most frequent below the ileo-cecal valve, the reverse being true in acute obstruction. It must be remembered in this connection, however, that chronic obstruction is liable to become acute at any time. The chief mechanical conditions which produce obstructions are volvulus, intussusception, internal hernia, foreign bodies, stricture, bands, adhesions, diverticula, and fecal impaction.

Volvulus, or a twisting of any part of the gut upon its axis, is of all degrees, from a quarter to a half-turn, or even a complete rotation upon its axis. It is most frequent in adult males, and constitutes about 4 per cent of all intestinal obstructions. The conditions which favor volvulus are, a long mesentery and intestinal adhesions to the abdominal wall. The most frequent location is at the sigmoid flexure, and one of the chief dangers is rapid gangrene, from interference with circulation.

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Experiments made by Senn and others go to prove that flexions alone are insufficient to cause obstruction, but in connection with adhesions, which prevent compensatory dilatation and peristalsis, is not an uncommon cause. Among the most fatal cases are obstructions caused by adhesion of the viscera to each other. Senn has collected fourteen cases in which secondary laparotomy succeeded in saving only one, and advises the necessity of prophylaxis in preventing adhesions after abdominal section, by covering in all raw surface, so far as possible, if necessary with omental grafts.

Bands and diverticula as a cause of intestinal obstruction are second in importance to intussusception. Ligamentous bands resulting from old adhesions are most frequently found in those parts subject to peritonitis, namely, in the pelvic and appendicular region. Also, they are found in the umbilical region from the obliterated omphalo-mesenteric vessels. Meckel's diverticulum, when its free end becomes fixed by adhesions, may cause obstruction. Halsted of Chicago (*Annals of Surgery*) has collected sixty-nine cases of obstruction due to this cause.

In rare instances the appendix vermiformis may act as a constricting band. Some months ago at Louisville City Hospital I operated on such a case, and found present eighteen inches of gangrenous intestine. The free end of the appendix had become attached to the margin of the pelvis, and through the ring thus formed the intestine had slipped and become strangulated.

An interesting case of displaced ring of a hernial sac came under my observation March 29th of the present year. A strongly built, well-nourished man, nearly 60 years of age, who had suffered with inguinal hernia for years, was taken with symptoms of acute obstruction, pain and vomiting being especially marked. When first seen this had continued four days. Examination showed the inguinal canal free, but on passing the finger deeply through it I could just feel an enlargement or mass. Exploration through a medium abdominal incision revealed an unyielding fibrous ring firmly constricting a loop of the small intestine, which was strangulated and deeply congested. The sac was removed and the ring sutured up to prevent a recurrence, the patient making a nice and gratifying recovery. Kurz reports a similar case in which the colon was constricted and the ring was found four inches from the inguinal canal.

From a surgical, as well as a medical standpoint, intussusception is the most frequent and consequently most important form of intestinal obstruction. It occurs in both the small and large intestine, but is more frequent at the ileo-cecal valve, especially in children. Fifty per cent of all cases of invagination occur in children under 10 years of age, and it is the cause of intestinal obstruction in over three-fourths of all cases

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occurring in children. The latter is an important point to remember for diagnostic purposes. The amount of bowel involved may be a few inches or a few feet. The lumen of the bowel may not be entirely closed, but is apt to become so as edema and constriction increase.

The blood supply is usually interfered with at the neck, and ulceration, perforation, or gangrene results. Chronic invagination may be produced by a tumor, and is common in the large intestine, or it may follow acute invagination, from sloughing.

Fecal impaction is almost invariably found in the large intestine, in the rectum, sigmoid flexure or cecum. The bowel in some cases becomes enormously distended, and these patients are constipated, or have constipation alternating with diarrhea.

Firm pressure under anesthesia produces a dent in the tumor present. Strictures constitute a large percentage of the chronic cases of obstruction, and may be of either a malignant or benign character. The most common location is in the ileo-cecal region, or the rectum. There is usually a history of gradually increasing difficulty in evacuation, or diarrhea alternating with constipation, or a bloody, mucous discharge from ulceration, may be present.

In diagnosing acute intestinal obstruction, four clinical symptoms are our chief guides, namely—intermittent, colicky pain, vomiting, tympanites, and absolute obstipation. The pain is caused by the violent peristalsis of the bowel. It is intermittent in character, is not aggravated by pressure, and is apt to be referred to the umbilical region.

Vomiting is present in all cases, and is earlier and more persistent the nearer the obstruction is to the stomach. There may be no nausea. The vomited material consists first of contents of the stomach, then bile, and sooner or later fecal matter.

Tympanites is more marked the farther away the obstruction is from the stomach, and may be almost absent in high obstruction. It is due to accumulation of contents of the bowel, with the formation of gas, and finally to paralysis. The obstipation is in nearly all acute cases complete, and any action from the bowels is from below the obstruction. To further differentiate obstruction from peritonitis, which it most resembles, the pulse, temperature, tenderness, and muscular rigidity must be taken into account. The pulse in obstruction is at first slow and full, in peritonitis rapid, wiry and small. The temperature, until there is complication, is normal, or nearly so, while in peritonitis it is increased, or, in the worst cases, subnormal.

Rigidity of the abdominal muscles is usually absent in obstruction, but is always present in peritonitis, as is also tenderness, which is usually absent in obstruction. The greatest difficulty is in those cases in which both conditions exist.

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The clinical evidence of chronic obstruction is progressive impediment to the passage of feces. It usually occurs in persons advanced in years, is most commonly present at the ileo-cecal valve or at the colon. Most cases are due to cicatricial contraction, or to malignant tumors; more rarely to benign tumors, or to extrinsic pressure. A history of diarrhea alternating with constipation is suspicious. There are frequent attacks of colicky pain, gradually increasing distention, and peristaltic action of the intestines visible through the abdominal wall. This latter sign, when present, is of very great diagnostic value in both acute and chronic obstruction. It is never present in peritonitis, but cannot be seen in thick-walled individuals.

A far more difficult task than the diagnosis of obstruction is the differentiation of the different varieties, and location of the obstruction. While this is most desirable, and in many cases a probable diagnosis can be arrived at, in perhaps a majority of cases it is impossible. However, there are certain symptoms peculiar to the different varieties. A sausage-shaped tumor and a bloody mucous discharge are characteristic of invagination, and, as already stated, over three-fourths of all cases in children under ten years of age are due to invagination.

Volvulus, if seen early, is characterized by a localized area of tympanites, due, as pointed out by Von Wahl, to the twisted loop becoming first distended. A localized tumor and tenderness are also early manifestations.

Diagnosis of obstruction due to bands and diverticula can only be problematically arrived at by excluding other causes and remembering that after invagination they constitute the most common varieties, and are more frequent in mature life.

The history of the case is valuable diagnostically in gall-stone impaction, and from foreign bodies and parasites. As a guide-post in chronic obstruction I can do no better than to quote Senn. "In infants and young children, chronic intestinal obstruction usually indicates chronic invagination; in young adults, cicatricial stenosis or compression of the intestine by a tumor; in persons advanced in years, malignant disease." These points, together with a careful history of the case, will clear up the diagnosis in a majority of cases.

Successful treatment of mechanical obstruction requires early diagnosis, and immediate operation. With very few exceptions medicine promises nothing, and the death-rate will continue to be appalling until the physician stops dallying with medicine and resorts to surgery before paralysis, gangrene or other irreparable damage has resulted. Only in cases of dynamic obstruction does medicine supersede surgery. Until operative interference is instituted all are agreed that stomach-feeding should cease absolutely, copious enema should be administered, and lav-

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age of the stomach should be instituted, and frequently repeated. Food and water taken into the stomach are not only not absorbed, but they increase the intestinal contents, cause retching and vomiting, and aggravate the intestinal peristalsis. Food and water must be supplied per rectum, and by intra-cellular saline infusion.

Lavage of the stomach is also a valuable adjuvant, too frequently neglected, for, as Kussmaul has pointed out, it decreases the distention of the bowels, diminishes peristaltic action, and relieves pain, eructation and vomiting. No matter how great the temporary relief may be, it should never be temporized with as a curative measure. Copious enema are so instinctively resorted to, even by the laity, that we need only mention it in passing. The too frequent use of cathartics can hardly be sufficiently condemned. They only tend to increase the intestinal contents, and stimulate the fury of the stormy peristalsis.

The distention of the colon with fluids or gas has been a recognized method of treatment for ages. They have been successful in a limited number of cases, principally those of intussusception. It is still a disputed point among experimenters as to the possibility of forcing water beyond the ileo-cecal valve. While in individual cases it has been accomplished, it is fraught with so great danger of rupture of the bowel that it should never be attempted. Hydrogen-gas and air can be much more readily forced beyond the valve, as has been shown by the extensive experiments of Senn and others. The passage of the gas through the valve is said to give a gurgling or blowing sound. Several observers, however, consider both hydrostatic pressure and the insufflatian of gas as an unsafe method. Bryant reports four cases of rupture, from twenty cases treated by insufflation for intussusception. Knaggs collected eight somewhat similar cases where either air or water produced a like result. Air or hydrogen-gas are, no doubt, preferable to hydrostatic pressure, because of their elasticity and expansibility. Any of these agents should be used with the greatest gentleness and caution. A steady, slow, continous injection, or insufflation, is far less likely to do harm than a sudden, intermittent one. There is greater danger in children than in adults. The patient should be under a general anesthetic. With these facts in mind we say that the use of hydrogen-gas, or air (less preferably, water) is a justifiable procedure in invagination below the ileo-cecal valve, especially during the first twelve or twenty-four hours of the attack.

In the vast majority of cases celiotomy is the only rational treatment, and should be undertaken not as a last resort—as is too frequently the case after paralysis and fecal vomiting are present—but just as soon as a probable diagnosis can be made. Let it be an exploratory incision, if need be, to clear up a doubtful diagnosis. Regarding the location of the incision we must remember that nine-tenths of all cases of obstruction

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are below the umbilicus, most frequently in the right or left inguinal region. If the obstruction can be located the incision should be made over the seat of the lesion, in other cases, in the median line. A free incision is usually required, with a visual examination, and more or less eventration of the bowels. The bowel is always collapsed below the seat of the obstruction; distended above it. The various operative procedures that may be required are numerous, the simplest, and one that any physician should be able to do in an emergency, is enterostomy. The incision is made in the right inguinal region, and the opening made in the first loop of intestine that presents. Colostomy may also be done in either inguinal region. Neither of these operations are ideal or to be recommended, except in extreme cases where more formidable measures are out of the question. The operation should aim to remove the obstruction or render it innocuous, and re-establish the intestinal continuity. This may require resection, lateral anastomosis, the mere severing of the bands or diverticula, the removal of a foreign body, the reduction of strangulations, intussusceptions or twists. Distended bowel, if necessary, is punctured or incised. The operation may be very simple or it may be formidable. And I would emphasize, in closing, that it becomes unpromising and uncertain in direct proportion to the delay in resorting to it.

DISCUSSION:

J. J. THOMPSON, M. D.: I don't know that I can offer anything more to what Dr. Coon has suggested in regard to obstruction of the bowels. I would simply emphasize the fact that the family physician should recommend, and the family should call the surgeon in time to save these cases. Last summer, twice within ten days, I operated, and I am sorry to say that I lost both cases. They did not die from the effects of the operation, but from the obstruction, being practically moribund when placed on the table. Now, it is all wrong to let these cases of what are presumably obstruction, wait for hours, sometimes days, before recommending surgery. It seems to me that even those of us who pride ourselves on being very conservative in surgery, should in this matter at least not hesitate to enter the abdomen. Conservatism in the sense that we are putting off the operation is very poor policy. So far as the method of operation is concerned, the Doctor went over that pretty carefully. I do not know as I could offer any suggestions beyond this, that it is not always necessary in these cases to wait for the surgeon, for the family physician, if he has the ordinary apparatus, can do the operation very nicely himself, if he cannot get a surgeon with all the modern instruments, by taking a little time and using ordinary precautions in anastomosing the bowels. After an operation of this kind you can get very good results. Of course, it is all well enough if you have the Murphy or Senn rings, or any of the modern improvements, but I should not wait for these. It is important, there is a life at stake, and I believe it is better, even if you are not particularly

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experienced in abdominal work, to go in and get relief for your patient rather than let the patient go on and die without any effort on your part.

L. K. MAXWELL, M. D.: The Doctor speaks of stricture as one cause of obstruction, and he speaks of no method of treatment except surgical treatment. I have in the past few years had several cases in which the thorough dilation, where the stricture was in reach, with a bougie, has succeeded in overcoming the stricture and restoring the individual to health. Eight years ago I had a patient forty-eight years old who had been troubled with obstipation for a long period of time, and it had reached a point where it was almost obstruction. She consulted a prominent surgeon in a neighboring city, and he told her nothing but a surgical operation would relieve her. The trouble was just above the sigmoid. I treated her by dilation with a bougie and introduced a large quantity of cotten-seed oil, from one pint to two or more, whatever we dared to introduce. We got the fecal mass started, got away a large mass of feces, and continued dilation. In the course of six months I had effected a perfect cure. There has been no return of the trouble. The woman is now in perfect health. About five years ago I had a patient about seventy-two years old in which there had not been a free movement of the bowels for fully four weeks. The patient finally ceased to have any bowel movement for about one week, and had been taking enemas of soap-suds, but got no result from it, and was at the time I first saw her vomiting feces. I introduced the bougie and oil, a considerable quantity at a time, until I got the mass above the stricture out of the way enough to admit the bougie, and then threw in a larger quantity of oil and got the bowels to move and fully cleared of feces. The bowels were so loaded you could see every convolution. The patient was quite emaciated. I dilated continually for a period and got the patient in very good condition, which lasted about six months, and then was suddenly taken off by an acute condition. An autopsy revealed a thoroughly organized stricture which we had been able to partially overcome, and allow the bowels to move. It was about two inches above the sigmoid. There had been obstipation for ten years previous to that. Operative treatment would not have been advisable or allowed in this case.

GEO. S. COON, M. D.: I think the members who have discussed the paper have brought out a good many excellent points. I think Dr. Briggs must have misunderstood me in saying that there is always absolute constipation. There is usually absolute obstipation in acute obstruction. In chronic obstruction there are discharges at times. In regard to lavage, of course my own experience is necessarily limited, as is every surgeon's, but so marked has been the relief in some of these cases reported by other surgeons that the operation has been delayed because the vomiting ceased and the distention rapidly improved, and it has been recommended, I think by Kussmaul, I am not certain in regard to the authority, that by use of the douche you can relieve very largely the gas above the obstruction, not only the stomach but the gas and distention in the bowels, and the reason that I mentioned that lavage should not be depended upon is that it has been depended upon in some cases fatally to the patient. I still hold that wherever found, in

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spite of Dr. Briggs' differing with me, in acute obstruction cathartics had better be let alone. Now the cases he has mentioned, appendicitis, are not cases of acute mechanical obstruction, unless you have the appendix forming a loop, or band, you might call it, which constricts. In the ordinary case of appendicitis, if you have obstruction, the symptoms are due to inflammation, and are dyanamic in character. It is in the mechanical obstruction that you want to cut out your salts and calomel and other cathartics. In dyanamic obstruction use them. If you believe it is a case of dyanamic obstruction, then you are perfectly justified in using cathartics, but I do not believe in other cases of obstruction, acute mechanical obstruction, that cathartics should ever be used. That intestine is already being whipped to death, and your cathartics only put a spur into it. Consequently, leave them out. Now, in regard to what the last speaker said about stricture. I will say that of course the paper was necessarily limited, and I could not take up all the points. Stricture is not usually amenable to dilation. It usually fails. It can be used, of course, as long as it gives relief, and provided there is not too much ulceration above the stricture. If there is, you are on dangerous ground. You are on mighty dark ground in attempting to dilate. The ulcer may go on through and cause death from peritonitis. The usual history of these cases of stricture is that very few are amenable to dilation; there may, of course, be exceptions in some cases of stricture low down, but I hardly believe a stricture above the sigmoid would be a case where I would want to attempt dilation. The results he got have certainly justified the means, except in one case where the patient died. I don't know whether opening the bowel above would have saved the patient or not.

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NARCOSIS PARALYSIS, WITH THE REPORT OF A CASE

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It has been observed in innumerable cases that nerve lesions, at times, follow the administration of general anesthetics. No portion of the body seems to be exempt from its baneful influence. The nerve-supply of a single muscle, groups of muscle, causing paralysis, or the great central nervous system, may become involved, terminating the life of the patient by a rapid general progressive paralysis. The kind of anesthetic nor the mode of its administration seems to have nothing especially to do with the result.

If we will take pains to look up the subject we will find that the literature is very extensive, and that the trouble has been the theme of many a discourse. It should be of interest to every operator, since he may at any time be confronted with such a case that may entangle him in litigation.

This form of paralysis is most commonly found in the arm, and is, therefore, by many writers, attributed to an injury of the brachial plexus by pressure of the head of the humerus, incidental to holding the arm in an unnatural position. Nonne, Hoodemaker, Bernhardt, and others, claim that when the arm is extended and abducted, the plexus is compressed between the clavicle and the sixth and seventh vertebræ. There can be no doubt but that this injury, resulting in paralysis, can be and has been inflicted in this way; yet there are many cases reported in which no such pressure occurred.

From rather an extensive study of the subject and a limited experience, I am led to the belief that we have here, in some instances, at least, a true neuritis caused by the toxic effect of the anesthetic. The cases that have come under my observation present much the same symptoms and pursue about the same course as does that malady. While it is true the onset of the disease is sudden, the paralysis usually being established in twenty-four to forty-eight hours, yet this is not more rapid than we sometimes find it developing from other causes.

Cases of central paralysis are rare, yet they are of sufficient frequency to prove conclusively the correctness of the theory that the lesion is due to anesthesia.

In the February issue, 1897, *Annals of Surgery*, p. 205, De Forrest reports four cases in which post-narcosis paralysis of the arm occurred, and in each case the cause of trouble was attributed to the position in

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which the limb was held. In three of these the deltoid and muscles of the upper arm were profoundly involved. Dr. McCosh, in the January issue, 1892, *Annals of Surgery,* p. 109, reported one case where both upper extremities became paralyzed owing to the position of the arms being thrust back under the head during a long operation. In one of the arms it was more than two years before complete recovery took place; at the same time he speaks of another case that came under his observation in London, where, after an operation for gall-stones, complete paralysis of one of the upper extremities followed, which lasted six months. Dr. Curtis, in the same article, refers to a number of such cases in which the arms were held in various positions—by the side, over the head, etc. In the *Annals of Surgery,* June, 1897, p. 197, De Forrest reports a case of central nervous paralysis, complete left hemiplegia, following Halstead operation upon the breast; the patient died on the eighth day after the operation from a progressive extension of the paralysis. Another case of central nervous paralysis is reported by Dr. Garrigue, in the January, 1897, issue of *The American Journal of Medical Sciences.* Another in the *Bulletin of the Royal Academy of Medicine,* of Belgium, No. 2. There may also be found a report of two cases of central narcosis paralysis in *Centralblatt fur Chiurgie,* No. 35, September, 1898.

My own case was a peculiar one, and, in some respects, I might say, rather sensational.

In August, 1899, I operated upon a patient, Mrs. B., for cholelithiasis. The operation was a severe one and somewhat protracted, as gall-stones were found in the cystic, hepatic and common ducts, and some difficulty was experienced in removing them. Upon visiting my patient the next morning I found that the entire right upper extremity was paralyzed, even to the ends of the fingers. She complained of numbness and tingling in the fingers; had impaired, but not loss of, sensation. My regular anesthetist was on the eve of leaving town, and was breaking in another man for me; therefore you might say that two physicians were giving the anesthetic. They both testified, as well as the nurses in attendance, that during the entire operation the arms were lying comfortably folded across the chest; this was also in accordance with my observation. Therefore the paralysis could not well have been produced by pressure of the head of the bone against the brachial plexuus. To me it seemed that the lesion was due to the anesthetic, and was possibly a neuritis of toxic origin. However, let this be as it may, there was complete paralysis of all the muscles of the right shoulder and arm, entirely disabling the member, even to the tips of the fingers.

As I was going to leave within a few days to be gone for three months, the case was turned over to another physician, who, upon his

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first visit alone, promptly proceeded, so I was told, to inform the friends that the arm was dislocated (without having made an examination). Under the circumstances, I saw the case the next morning and in the presence of the physician, husband, mother of the woman, and two nurses, stripped her to the waist and made a most careful examination of the case. The arm, lying powerless by the side of the patient, could be put in any imaginable position without either pain or resistance, and, excepting a slight sagging of the head of the humerus, caused by relaxation of the deltoid and the ligaments about the joint, all the anatomical points of the shoulder were resting in their normal position. I positively pronounced, in the presence of them all, that the arm was not dislocated, but that the case was one of paralysis, caused possibly by some injury to the brachial plexus either from pressure or the toxic influence of chloroform. I left town the next day and heard nothing further from the case, excepting an occasional hint of a suit for malpractice, until my arrival home three months later. Upon my return I found the patient not only suffering from paralysis, but from the effects of a false diagnosis of dislocation, as well, and learned that frequent unsuccessful attempts had been made to restore the supposed luxated joint, the only result being a severe contraction of the biceps tendon, incident to the flexed position in which the arm had been held for several weeks by bandages. In the presence of the mother and physician, after hearing his statement that he had been entirely unable to reduce the luxation and maintain the head of the bone in position, I again stripped the patient to the waist and made another most careful examination, and found that excepting a slight sagging of the head of the humerus, caused by the relaxation of the deltoid and the ligaments about the shoulder, there was nothing abnormal about the joint save those atrophic changes following the paralysis. The anatomical relations about the shoulder were all intact, the arm could be put in any position without resistance or pain. I again announced to the patient in the presence of the physician, that the arm was not dislocated nor had it ever been; that it was paralyzed, and would in time recover. A few weeks' treatment by massage and the Faradic current restored the limb perfectly to its form and function.

The doctor in question has never had the honesty to acknowledge his wrong to me and injury to the patient. I hear that he is yet telling that he caught me "up a tree' in diagnosis in a case of dislocation of the shoulder-joint.

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CHOLELITHIASIS, APPENDICITIS, SALPINGITIS, PERITONITIS—WHEN SHOULD MEDICAL TREATMENT CEASE AND SURGERY BE INVOKED?

HORACE PACKARD, M. D.
BOSTON

The subject announced for this paper is very broad, and either one of the topics might furnish material for a whole session.

It is not my purpose, and, indeed, it is quite unnecessary, to go into an elaborate consideration of the etiology and pathology of these diseases. Their symptoms and causes are well known to you, and at first thought it would seem that each is sufficiently defined so that no confusion would ever arise in differentiating them. It is a fact, however, that occasionally a case diagnosed as appendicitis turns out to be gall-stones, and *vice versa,* and that right-sided salpingitis has not infrequently been diagnosed appendicitis, and while general peritonitis may take its origin from any of these diseases, it sometimes arises entirely independent of them. Hence, it is the atypical forms of these diseases, or those forms which are most likely to resemble each other, that I desire to speak of by way of introduction.

The gall-bladder, under normal conditions, is situated high up under the costal cartilage and ribs, and cannot be felt by palpation, even in the thinnest subjects. Our ordinary conception of gall-stone disease is, frequently-recurring biliary colic, caused by the passage of a gall-stone through the cystic and common ducts, accompanied by jaundice and gastric disturbances. But gall-stones frequently exist without such a train of symptoms ever having occurred, and post mortem examinations show that often gall-stones have existed for years without causing any conscious trouble, and the patient has succumbed to some other disease. Such gall-stone cases are those in which the concretions are large in size such as these which I now show you. Not one of the stones being small enough to pass through the outlet of the gall-bladder. Often the smallest one is of a diameter to permit of its incareeration at the very beginning of the cystic duct.

With such stones, the physical conditions are favorable for trouble, which comes about in this way: The normal mucous secretions of the gall-bladder lining is prevented from making an exit by this valve like arrangement, or plugging of the duct. It is possible that some bile may get into the gall-bladder, crowding its way by the obstruction. There frequently comes to be, as a result of this obstruction, a

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gradual distention of the gall-bladder. This distention is tolerated for a time, and if it proceeds slowly the muscular walls of the gall-bladder become thickened, because they are ever resisting this disturbance, in their endeavor to expel the contents. With the increased distention there frequently occurs pain in the right hypochondrium, with gastric disturbance in the shape of nausea and vomiting, but no jaundice. Examination shows a tumor projecting below the costal cartilage of the right side, and sometimes reaching as low as the umbilicus and crest of the ileum. Careful analysis of the symptoms in these cases will almost always disclose the fact that pain is felt, or has been felt, in the back or under the right shoulder-blade. This is not all; a gall-bladder containing gall-stones is quite sure to be also the habitat of pyogenic bacteria. This intrudes the element of suppuration, and it is not infrequent that empyema of the gall-bladder is an accompaniment—if so, then elevated temperature and pulse will co-exist.

This is the form of gall-bladder disease which may be erroneously diagnosed as appendicitis, because the tumor reaches far down into the right iliac region, the pain and tenderness are on the right side, and the gastric disturbances are similar to those of appendicitis, and there is fever and increased rapidity of pulse. When surgical treatment should be invoked for such a form of cholelithiasis admits of no difference of opinion.

Operation should be performed as soon as a bunch is felt in the right hyochondrium. However much latitude is warrantable in other gall-stone cases, none is permissible here. The danger which menaces your patient is a very grave one. There is no mucous-lined cavity of the body, whether it be the urinary bladder, the appendix, the Fallopian tube, or the gall-bladder, which can be safely left to nature when the normal aperture for drainage is occluded. In all of these, occlusion and distention will be tolerated up to a certain limit. After that, either from gangrene of the wall, or perforation by destructive ulceration, calamitous injury will follow, which is likely rapidly to result fatally.

Let us trace out the physical changes which are likely to occur in distention of the gall-bladder. The hepatic arterial branches ramify over and through the walls of the gall cyst. With accumulation of material within the gall-bladder, whether it be mucus alone, or associated with bile and pus, there comes a time when the intra-cystic pressure equals or exceeds the blood-pressure. Stasis follows. The next step is gangrene, and then perforation.

Sometimes nature kindly provides for this by setting up adhesions between the menaced portions of the gall-bladder wall and a neighboring loop of intestine of the abdominal wall, wth final discharge of the contents into the intestine, or externally. That this form of gall-blad-

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der disease is common, permits of no doubt. It is a frequent occurrence in the practice of many physicians to meet cases of "enlargement of the liver," so diagnosed because the liver dullness is found on percussion to extend considerably below the usual line; sometimes below the costal cartilage. Such enlargement, if accompanied by tenderness and pain, attacks of nausea and vomiting, elevation of temperature and pulse, or even sometimes without the latter, I believe to be almost invariably produced by gall-stone disease. Allow me to reiterate that in every respect the patient's interest is best subserved by an early operation—as early as tumefaction can be diagnosed.

Appendicitis is now such a well-understood disease that there is rarely much delay in reaching diagnosis; however, the appendix varies considerably in location, and this very variance gives rise to possibility of error. With an appendix which is located post-cecally, and extends upward, with the extremity reaching nearly to the level of the umbilicus, it is very apparent that the accompanying tenderness and tumor, if such has formed, may be located so high as to occupy the upper part of the right lumbar region, or encroach upon the hypochondrium. This would naturally give rise to suspicion of gall-stone disease rather than appendicitis. Again, were the appendix hanging directly downward from a long cecum, the tip easily reaches the cavity of the pelvis. The tenderness and tumefaction, if such exists, might easily be attributed to tubal disease in the female. Sometimes the appendix stretches directly across the abdomen, reaching to or beyond the median line. This will again result in symptoms which may be misleading, and give rise to suspicion that the trouble originates from other than appendix.

The very earliest symptoms accompanying appendicitis are of the utmost value in reaching a diagnosis. It seems to me of the greatest utility to carry together in one's mind the physical changes, and the general symptoms. I think that it is safe to say that every case of appendicitis began as an obstruction, either from some congenital or acquired stricture, or the formation of a concretion, which finally occludes.

Earlier in this paper I have dwelt casually upon distention of mucous cavities, and that such distention is bound to result in pain sooner or later.

If we follow this same analysis with the appendix, we find that its total capacity is so small that a comparatively small accumulation, perhaps no more than two teaspoonfuls of fluid, distends it to its utmost capacity. Supposing then the existence of a stricture or a stone. There comes a time when the obstruction is complete, distention begins, and goes on until one of the following things occurs:

First. The intra-appendiceal pressure becomes sufficient to over-

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come the obstruction offered by a moderate stricture or calculus, and the fluid is discharged, the patient is relieved, recovers with but moderate disturbance, and goes on in good health until recurrence takes place. These are the recurrent cases.

Second. The obstruction is complete, does not give way, the intra-appendiceal pressure becomes equal to or exceeds blood-pressure, then circulation through the appendiceal arteries ceases, gangrene follows, with perforation.

Now, what have been the symptoms during this change? There first has been pain in the epigastrium or umbilicus. Curiously, the first pain of appendicitis is rarely if ever at the site of the appendix. The explanation of this is that the appendix receives its arterial supply from the superior mesenteric artery. The nerve-supply of the appendix accompanies it, and thus communicates with the spinal nerves at the higher point. The pain is thus felt where the nerve impulses are received, rather than where they originate, namely, around the umbilicus or near the epigastrium. This is one of the misleading symptoms of appendicitis, and the existence of such would always arouse the suspicion of an obstruction or distended appendix, and suggest to the mind that the next change which may occur in the appendix is gangrene and perforation. It is quite unnecessary for me to declare to you that perforation of the appendix is one of the most menacing accidents which can occur, for with it comes most imminent danger of infection of the peritoneal cavity, and death.

Going back, then, to the subject of this paper, namely, "When Should Medical Treatment Cease and Surgery be Invoked?" With this view which I have laid before you, there can be but one opinion regarding appendicitis namely, that it should be resorted to before rupture has occurred. If this could be done in every case, there would never be a fatal appendicitis.

Coming, now, to the practical side of the question, is it possible always to know when rupture takes place, or to anticipate it by an operation? I admit that under the present conception of the disease by the laity, it is not. I wish that the public might be taught in a plain and convincing way the true significance of appendicitis. I think that the public press is much to blame for the attitude at present held by the laity. It has been a custom to refer in a slurring way to the "New Disease," and call it a "Doctor's Fad," and "Wonder how long it will have its run?"

I wish that the public could be made to understand that this is not a new disease, but is what used to be known as "inflammation of the bowels." The fatality of appendicitis under its old name was well enough understood by the public; indeed, the report that an individual

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was suffering from "inflammation of the bowels" was almost universally accepted as the forerunner of his death and funeral. I wish that through the columns of the public press the people might know that appendicitis is one of the most treacherous diseases to which the human family is subject, and that when patients die, they die of the disease, and not because of the operation.

The inference has been made to go forth in some way, that doctors want to operate upon every case of appendicitis, as though it were a privilege to him rather than to the patient; and the thought exists in some directions, even in the medical profession, that surgeons have gone sort of crazy over the surgery of the appendix. Such I wish to disclaim. There should be, and I believe is, only in the minds of the medical profession a devout desire to avert disaster and save every life possible. In this disease, appendicitis, would every patient be willing to submit to the advice of the physician sufficiently early, death need never occur. Here is an obstacle which will continue to intervene and prevent us from doing our best, although already there is evidence of a more rational attitude by thinking people. Your own conviction as the medical attendant, and the assumption of a positive attitude in diagnosis and advice, will do much to convince your faltering patients. It is true that many people are still neglectful about summoning medical counsel in cases of abdominal disturbance; the physician is sometimes not summoned until the golden opportunity is passed, irretrievable damage has been done, the appendix has ruptured, and peritonitis is established. It is sometimes that the optimistic physician, though summoned early, comforts himself with the thought that even if this be a case of appendicitis the patient may "pull through," and three or four days pass, by which time the damage is done. The septic infection has reached the peritoneum, has become general, and the patient is beyond help, or maybe operation is performed, and the patient dies, and the verdict is, "operation killed him."

I consider the following train of symptoms sufficient to establish a diagnosis of appendicitis, and I never hesitate in their presence to urge operation with all the vehemence I possess.

1. In the beginning of the attack pain in the epigastrium, or about the umbilicus, with or without nausea and vomiting, with or without loose movements of the bowels.

2. Later, tenderness in the right side of the abdomen, focusing finally in the right inguinal region, with distinctly localized pain or tenderness, or both, with or without rigidity of the right abdominal muscles.

A tumor and dullness in the appendiceal region following the above symptoms is presumptive evidence that the appendix has ruptured and

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that a circumscribed peri-appendiceal abscess exists. This lessens the immediate urgency of operation. There is, however, the ever-present danger of systemic absorption and general septicemia, necessitating watchfulness and readiness to evacuate pus, even if the appendix be not removed. It is at this stage that opponents to appendectomy may present plausible arguments in favor of medical treatment. The golden opportunity for the surgeon has passed. Damage has been done which no operation can, with positive certainty, repair.

Appendicitis may be compared with a conflagration. In the first few minutes of a fire is the golden opportunity to extinguish it without damage to adjacent material. The first few hours of an appendicitis affords the golden opportunity to avert the danger without damage to adjacent parts.

To summarize, I would say that in first attacks of appendicitis operations should be performed as soon as a diagnosis can be made—within the first twenty-four hours, if possible. In recurrent attacks, more latitude can be allowed. It is a fact that not infrequently people have recurrent attacks of appendicitis which have never been recognized as such. Possibly they go through them without medical treatment or advice. Such patients are likely to have them and recover from them, although at any time they may assume alarming symptoms and be fatal; these should be operated upon between the attacks. The danger accompanying the removal of the unruptured appendix is, under modern methods of surgery, and in skillful hands, zero.

Pain and tenderness in the right inguinal region, if it be in a female, should always arouse the suspicion of salpingitis. If the pain and tenderness occur simultaneously on both sides, the probabilities lead still more strongly to a diagnosis of tubal disease. Vaginal or rectal examination should never be omitted. The presence of a tender bunch at the right of the uterus, easily palpated by the tip of the forefinger, and the discovery of a similar condition of the left side, is sufficient to exclude appendicitis, unless the latter be an accompanying sequel. The pain of a salpingitis originates low down in the abdomen, and remains there. There is never the epigastric and umbilical pain of appendicitis unless the latter be an accompaniment by encroachment. It is occasional that a low-lying appendix becomes adherent to an infected tube, and becomes in turn invaded. This may result in a very complex and mystifying train of symptoms. Much more latitude in treatment is permissible in the majority of cases of salpingitis than in appendicitis.

Tubal infection is usually of gonorrheal origin, which is not very virulent, as far as menace to the general peritoneum is concerned. The menace is much greater if the tubal infection follow instrumental interference or confinement, for then the infecting material is likely to be

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pyogenic in character, and have a degree of virulency very menacing. These are the cases which spread to the general peritoneum and produce death. In general, I should say that it is quite proper to continue medical treatment of nearly all cases of salpingitis arising spontaneously, or which are traceable to gonorrheal infection, until the acute stage is passed. If pelvic abscess form and point *per vaginam,* open it and drain. If, after convalescence is established, inflammatory masses still exist which are painful and perpetuate invalidism, salpingectomy is the proper course to pursue.

Salpingitis developing after abortion or confinement, calls for prompt operation for removal of the tubes and possibly the uterus also.

Any of these diseases which have been dwelt upon are capable of developing into general peritonitis, and if such has been established, it is a question whether medical or surgical or any other means will save life. A prophylactic course, obviously, is the one to follow, that is, to cure the menacing gall-bladder disease, appendicitis, or salpingitis, before it has had a chance to do mischief to the peritoneum.

But there are cases of peritonitis which arise from other causes, happily rare, but nevertheless menacing. It is such cases which call for the highest degree of skill in diagnosis and treatment. It has become almost a matter of course in cases of abdominal pain to think at once of appendicitis or salpingitis as the cause. Failure to find early symptoms or localized conditions to account for such should suggest to one the possibility of a pneumococcus infection secondary to pneumonia or bronchitis, or an infection direct from the intestinal cavity through penetration of the intestinal walls by the colon bacillus.

In such cases of general peritonitis surgery does not offer a flattering hope. If there be so little normal resistance on the part of the patient's tissue that a pneumococcus or colon-bacillus infection has reached the peritoneum without solution of continuity, and has spread throughout, I am inclined to trust to the cold pack and the indicated remedy, rather than subject the patient, with already markedly depreciated vitality, to surgical treatment which in itself would be a profound shock to a well person.

In many cases of general peritonitis of so-called idiopathic origin, upon which I have operated, my thought has been that death has been hastened by the operation. It is difficult, however, to draw conclusions, for the fatality is great in this class of cases, under any treatment. In my earlier experience I was inclined to operate upon cases for which I now counsel medical and local treatment.

It is my belief that ninety-nine per cent of cases of appendicitis,

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cholelithiasis, and salpingitis can be diagnosed prior to operation, *i. e.*, that an exploratory incision is not necessary for reaching a diagnosis.

The remaining small percentage of inflammatory and menacing abdominal cases, must then be of the obscure origin described above.

Later experience has taught us that the peritoneum is not such a valuable structure as we once believed. We do know that it is a rapidly-absorbing membrane, and that septic matter is quickly carried from it to all other parts of the body. Whether a patient suffering with peritonitis lives or dies depends upon the limitations which the tissues and blood oppose to the disease, and the ability of the excretory organs to eliminate the poison, rather than what the surgeon can do, for he cannot sterilize an already infected peritoneum.

SUMMARY—*Dependence Upon Medical Treatment Should Cease and Surgery be Invoked:*

1st. In gall-stone disease as soon as distention of the gall-bladder is apparent.

2nd. In appendicitis as soon as a diagnosis can be made, except in some recurrent cases, and in some well circumscribed cases, in which sometimes, not always, medical treatment may be continued until the attack has subsided.

3rd. In salpingitis following instrumental abortion, and in the salpingitis of puerperal fever, and in chronic salpingitis when the acute attack has passed and there still remain tender and painful masses of thickened inflammatory tissue.

4th. In peritonitis originating from other sources than the above, and not due to penetrating wounds of the abdomen, the question is a mooted one, but the writer inclines to dependence upon medical treatment, holding in reserve exploratory incision if the diagnosis be obscure.

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RENAL ENGORGEMENT

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Engorgement, or congestion of the kidney, is recognized by all clinicians. But until quite recently clinicians have only been able to judge the condition, or rather what the condition was before death, by the appearance post-mortem, unless it were in case of accident, when the kidney might be seen through some abnormal wound, and then, most likely, in a normal condition. Through the agency of anesthesia and antiseptics, we can now touch, handle and see the kidney, and all its conditions and surroundings *in situ* in the living. Thus we are better prepared to tell what are the causes and results of the various symptoms which lead up to what has always been inferred from post-mortem pathology. In 1896 Reginald Harrison, of London, called attention to the fact that "in the cases of some patients suffering from symptoms resembling those caused by stone in the kidney, including some forms of albuminuria, exploration relieved all these disturbances, without resulting in the discovery of any distinct cause." This he ascribed to the relief of tension and congestion. Later in the *British Medical Journal*, from which we take the liberty of quoting, he stated that "there were good grounds for considering renal tension a pathological entity." Why the profession was so long in recognizing the true condition is that most of the diagnoses were made from post-mortem work, after changes had taken place which should have been prevented; still, they knew that such engorgement existed, as we shall see later.

We will try and deal with this subject briefly under three headings:

(1) What reasons are there for believing that the immediate effect of engorgement may be, with other causes, the starting-point for some of those pathological changes in the kidneys which are included under the term Bright's disease, or nephritis?

(2) In what class of cases are there reasons for thinking that direct surgical intervention for the relief of engorgement and its effects is applicable, and how are we to arrive at this conclusion?

(3) In what manner should the latter be practiced?

In reference to the first question, it must be borne in mind that the more recent information we possess about certain pathological disorders of the kidneys has been mainly derived from the actual inspection of the organ during life, and from the impressions conveyed by touching or handling it. It is hardly remarkable, therefore, that the effects of en-

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gorgement as a factor in these diseases could not in the past be fully appreciated. Now, a living kidney may be seen and explored with ease and safety. In looking over a description of the pathological conditions connected with various forms of nephritis, as we find them in the recent text-books, it is difficult to reconcile the following phrases used by eminent and accurate authors with an entire absence of all reference to engorgement as a cause of subsequent lesion and disease, and the necessity that may arise for its removal surgically.

If we turn to Dr. Delafield's admirable article in the *Twentieth Century,* published so recently as 1895, we shall find numerous references to kidney conditions in connection with nephritis, such as the following: "Commencing exudation," "commencing transformation of the exudation," "extravasations of blood in the Malpighian bodies, the tubes and the kidney tissue, and by filling of the tubes with coagulated fibrin," "the tubes are filled with degenerated epithelial granular matter, and fat-globules, or with a homogeneous exudation," "if the exudation between the tubes has become organized, we find masses of connective-tissue cells and fibres," and so on. Still more suggestive is the following passage: "Sometimes, particularly when the attack is the result of a definite exposure to cold, and the subject middle-aged and intemperate, an acute form of nephritis manifests itself which is characterized by extravagant congestion, even to chocolate or purple, and great and rapid swelling of the gland, so that, as I have seen in at least one instance, the kidneys have burst their capsules." "Short of this exceptional result, the whole organ, but chiefly the cortical tissue, is enormously swollen; the cortex changed to a deep coffee-color, and the cones to purple; whilst the tubes are distended chiefly with epithelium and blood." It is difficult to understand how, under all these circumstances, repair can be carried to a successful issue, without occasionally requiring some surgical assistance. The question has been raised, "How is it that the tension of acute nephritis never, or rarely, proceeds to suppuration or gangrene, as happens elsewhere in the body?" The answer is obvious: "These extremes are anticipated by death."

Besides the advantages gained by the direct examination of the kidney, there are some apparent analogies bearing upon internal tension which must not be passed unnoticed. All surgeons know the relief obtained, and the benefit to the structural mechanism of the testicle, in severe and distended orchitis, from one or more incisions in the tunica albuginea.

We frequently have transient, as well as permanent, evidence of the damage that inflammation and engorgement are capable of producing in this organ which, relative to its secreting and investing structure, is not unlike the kidney. We also have it well illustrated in inter-ocular

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tension by iridectomy in glaucoma. When you cut down upon the kidney, you find a wide range of conditions when first you touch the organ. If normal, the kidney has a soft, almost flabby, feel, as compared with the kidney that is inflamed or engorged. Even when you have had a great amount of suffering from stone, the kidney is not so tense and hard; and when you bring the congested kidney into sight, it has the dark, sometimes mottled, look, that is peculiar to an engorged kidney. Upon puncture or incision the blood spurts or pours out profusely. I have heard assistants or onlookers remark, "He has opened the artery."

The second division: What class of cases are suitable for surgical interference for the relief of engorgement, and how to arrive at this conclusion? Eliminating, as the kidneys do, diseased materials, which by their quality and quantity are liable to excite congestion within the kidneys, it is not surprising that in this way high degrees of engorgement are occasionally induced. These irritants are derived from various infectious diseases, such as scarlet fever, diphtheria, measles, and the like; from alcohol and food intoxicants, and from the excessive use of such drugs as turpentine and cantharides. It is estimated on good authority that, out of one million deaths, forty-eight thousand are from scarlet fever; doubtless a large number of these were from nephritis. It can perhaps be well illustrated by taking types representing three states of acute nephritis, which not uncommonly come under notice in connection with scarlet fever. First is the common type, where there are varying degrees of fever, rash and desquamation, with nephritis, indicated by blood in the urine, albumen, casts and epithelium. While the fever may be high, and the kidney complication severe, the tendency in every direction is toward recovery and complete restoration of all the organs involved; cases in this large class certainly do not require surgical attention, for recovery is steadily progressive.

The second group of cases, though apparently belonging in the commencement to the preceding class, does not end in the same way. The perfectly healthy adult or child passes through the earlier stage of the disorder much as the former, but the convalescence is delayed and the signs of nephritis, as evidenced by albuminuria and casts in the urine, do not disappear. The disease does not progress toward recovery, but is stationary, or tends in the opposite direction. These are the cases which furnish a considerable portion of those of chronic nephritis, or Bright's disease, and tend more or less to an invalid life.

The third class is taken from what has been described as the malignant type of scarlatinal nephritis. Here the kidneys appear to be at once overwhelmed in the pathological changes that supervene, suppression of urine occurs, and death rapidly follows from uremia, with coma and convulsions. After death under these circumstances it is usual to find

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the kidney intensely congested, the capsule tense and shiny, and overfilled with blood. However capable of gradual distension the capsule of a kidney may be, there is no doubt that it is very intolerant of any sudden increase of intra-renal tension, and experience gained in operating on that organ teaches that in certain conditions of engorgement the capsule is so tensely stretched, and its substance exposed to such pressure, as to explain any interference with its function. The results of operation also tend to show the importance of increased engorgement, for often after mere incision the quantity of urine excreted is found to have doubled within twenty-four hours. Here, then, we have two types of nephritis where little can be expected from medicinal treatment alone, which has been faithfully tried; the one being indicated by increased persistence of albumen in the urine, and further evidences of disorganization, at a time when recovery should be steadily progressive; and the other when the kidney is suddenly paralyzed by the extreme engorgement to which it is subjected.

There is another indication of engorgement in connection with renal inflammations and congestions which should not be ignored in deciding what may be required to meet the pressing emergency so occasioned. I allude to the tension which is thus thrown on the heart and the circulatory apparatus generally. This form of tension is generally recognized in connection with renal disease, though the explanation is not so universally appreciated. The action of the kidney has been compared to a steam-boiler; the boiler is composed of a number of tubes, by means of which the water can be quickly heated and transformed. If a number of tubes become damaged and inoperative, their temporary loss is provided for by a more rapid circulation of the water through those tubes that remain; this is brought about by a mere mechanism. In the same way with the kidneys when the uriniferous tubules become damaged or rendered inoperative by pressure and blockage, an increased circulatory force becomes excited. In the human subject this means cardiac hypertrophy and vascular tension throughout. If a certain amount of blood has to be driven through the kidneys in twenty-four hours for the excretory purposes of the body, it stands to reason that the forces to perfect this must be relative to the resistance offered. Cardiac effort may, therefore, be regarded as proportionate to, and determinate by, the latter. Dr. Dickinson, in "*Allbutt's System of Medicine,*" Vol. IV., observes: "I have distinctly recognized hypertrophy of the heart as a result of nephritis of not more than six weeks' duration."

The third division, viz.: In what manner shall we give relief in the above conditions? With chloroform as an anesthetic, and antiseptics, one approaches a wound-making procedure for purely therapeutical purposes with different feelings to those which prevailed before their adop-

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tion. The operation of exposing, and, if it is necessary, incising a kidney, is attended with little risk, and it should be done when there is a prospect of saving life or relieving a person from invalidism, as is certain to follow a chronic albuminuria after nephritis. If the surgeon is certain that there is no stone, simple puncture, or slight incision of the capsule along the convex border of the kidney, is all that is necessary. We prefer the incision. To reach the kidney you follow the same technique that you do for any operation on this organ. Whether the operation has been for stone where the kidney has been cut through, or for simple engorgement, a drainage must be left in contact with the kidney, to be removed when the conditions will permit; that is, when the urine ceases to flow, if it does, through the drain, and all blood and other discharges have stopped. The wound closes very quickly after the drainage is removed.

How can you tell which kidney to operate upon? Certainly, as a rule, both are affected, but often one more than the other. Which one is more affected will be indicated by pain and soreness of the affected one. Sometimes we find but one kidney affected. Should both kidneys be equally involved, it is a rule that, if one kidney be relieved, that relieves the other; and the flow of urine is normally established, as in the case of pressure of one kidney from external hemorrhage, the urine is sometimes almost totally suppressed. Removal of the pressure from the *one* kidney will relieve both.

Some Indications for Surgical Interference:

(1) Pain, or aching, in the renal region, often continuing over long periods of time, with acute exacerbations, with or without hemorrhage.

(2) Progressive signs of kidney deterioration, as shown by the persistence or increase of albumen when it should be diminishing or disappearing from the urine, as in the natural course of inflammatory disorders ending in resolution.

(3) Suppression of urine, or approaching this state.

(4) Where marked disturbances of the heart and the circulatory apparatus arises in the course of inflammatory renal disorders.

We will only tax your time and patience with the history of one fairly typical case. This is a synopsis of the report given by Dr. J. T. Leland, of Tintah, Minn., from his case-book when referring the case to me.

RENAL CALCULUS; NEPHRITIC COLIC.

August Brause, farmer. May 13 I was called at 9:30 p. m. I found the patient suffering from nephritic colic, involving the left side. Pain acute, extending down the ureter. Urine passed, containing blood. Pulse, 48; temperature, 98.3. History of lumbar pains extending over

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a period of two years, especially bad on the left side; noticed particularly in the morning. One year ago pain and tenderness were felt when walking. "Felt pain every time I stepped on the left foot." Man 43 years of age; weight, 105; always enjoyed good health.

Prescribed morphine, ¼ gr., hypodermically, at once.

Locally: Hot applications, lead-water and laudanum.

Internally: Belladonna, aconite, turpentine.

MAY 14, 10 a. m. Pulse, 48; temperature, 98.2; urine, dark-colored, but no blood. Vomited once. Pain not so severe, but present with exacerbations. Continued the remedies, with addition of alcohol steam-vapor baths.

MAY 15. Urine full, amber-colored; normal; slight trace of sugar. Sp. gr., 1030; pulse, 54; temperature, 98.3. Suffered considerable pain from 12 midnight until 3 a. m. Bowels constipated, and do not respond to cathartics or enemas. Continued *byronia, belladonna;* also gave *Salol,* 5 grs., three times a day.

MAY 16. Pulse, 60; temperature, 100.3 F. No movement of the bowels; pain better. Pain on urinating; smarting in the urethra. Urine normal in color and amount. Prescribed an enema of magnesium sulph., glycerin, aqua and turpentine. Result good.

MAY 17. Temperature, 100.2 F.; pulse, 66. Bowels moved twice on the afternoon of the 16th and twice on the morning of 17th. Pain not so sharp; no throbbing; no headache or chills. Urine: Uric-acid crystals; color normal. Gave *Salol,* 5 grs., in a glass of boiled water, four times a day; *Calcium sulph.,* 1 gr., every two hours until saturation; *Cantharis* internally every two hours.

MAY 18. Temperature, 100.3 F.; pulse, 60. Bowels moved freely at 3 a. m. Pain severe for about five hours during the night. Urine dark-colored; uric-acid crystals; scant in quantity; not significantly so, however. Diet, skim-milk. *Salol,* 5 grs., four times a day. Boric acid, 4 grs., alternating with *Salol.* Belladonna every hour, and if in severe pain, every 15 minutes. No swelling or tumor in the region of the kidney. Urination more frequent; considerable gas in stomach and intestines.

MAY 19. Pulse, 54; temperature, 99.3 F. Bowels moved. Pain present all the time, but not so severe. Urine clear; no uric-acid crystals. Sp. gr., 1025. Boric acid. Internally: *Byronia; potassium bitartrate; belladonna,* 5 grs., every six hours.

MAY 20. Pulse, 60; temperature, 99. Urine clear. Sp. Gr., 1023. Pain in the lumbar region. Bowels moved. Epistaxis. Passed a small stone(?). Slept well; severe pain began at 8 a. m.; lasted two hours; pain higher up.

MAY 21. Temperature, 98.1 F.; pulse, 48. Urine: Amount in twenty-

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four hours, 24 ounces; slightly acid. Sp. Gr., 1020. Free perspiration. Pain severe from 12 to 5 p. m. on the 20th. No passage from the bowels; feet cold during pain. After pain, profuse perspiration. *Byronia, belladonna,* and *strychnine sulph.* internally.

MAY 22. Pulse, 60; temperature, 98.2 F.; Urine, 30 ounces; light-colored no uric-acid crystals. Sp. Gr., 1020. Reaction slightly acid or neutral. Bowels moved this a. m. No pain since afternoon of 20th. Appetite increasing; looks better and is more cheerful. *Byronia belladonna.* Lithia tablets, alternating with *Boric acid* and *potassium bitartrate.*

MAY 23. Pulse, 66; temperature, 98.2 F. Urine, 28 to 30 ounces. Sp. Gr., 1020. Reaction neutral; no albumen; no pain. Appetite good. Continued remedies. Case dismissed with orders to remain in bed till Monday.

JUNE 17. Reports blood in urine; no pain. This due to lifting. Gave turpentine. History from this day was not kept. As I remember, he had one or two more attacks Sept. 7 or 8, from which he rapidly recovered.

On Sept. 17, 1901, Mr. B. went to St. Luke's Hospital. On the morning of the 18th we cut down upon the kidney, and found it engorged and swollen with dark chocolate spots, the size of a pea, over nearly every portion of the surface of the kidney. We made an incision through the kidney into the pelvis, explored the pelvis, both with the sound and finger, for stone or any foreign substance; catheterized the ureter, and found nothing. We then sutured the kidney with catgut, put gauze drainage down to the kidney, and closed the wound, deep with cat-gut, and the skin with worm-gut; dressed the case with the usual dry-gauze dressing, and put the patient to bed. He recovered nicely, and when thoroughly out of the influence of the anesthetic he claimed he had less pain from the wound and the kidney combined than he had been suffering for months; he urinated freely, more so than he had done for some time. The gauze drainage was removed on the third day, and he progressed with little or no pain and no rise of temperature, to perfect recovery.

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SECTION IN SANITARY SCIENCE AND PUBLIC HEALTH

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INFLUENCES THAT UNFAVORABLY AFFECT THE MENTAL AND PHYSICAL DEVELOPMENT OF THE INDIVIDUAL

RÉSUMÉ OF THE GENERAL SUBJECT

C. A. Weirick, M. D.
CHICAGO

Perfect health is that condition of the body in which every organ performs its function physiologically and acts harmoniously in its relation to every other organ.

The standard of health of any district is the average physical condition of its inhabitants. The writer's experience leads him to believe that very few adults are perfectly well, and that the standard is not high. It is the province of the Section in Sanitary Science to strive to raise the standard of health. Physicians need but recall what has been accomplished by sanitary and hygienic measures to appreciate their value to humanity in preventing disease. Even within the professional life of many here today the percentage of cases of variola, diphtheria, scarlet fever and typhoid fever has been materially reduced.

It is not about what has, but about what should be done, that I wish to write.

What class of causes of disease needs attention at the present time? The reply is, those which produce neurotic diseases, for they are the ones that are not diminishing in number. Insane asylums are filled to overflowing, more are being built, and yet the demand for room increases. It was stated not long ago on good authority that a large percentage of this class of cases comes from farmers' wives, and the reason given is their seclusion from society. The social nature cannot be suppressed with safety. The child gives it full vent, the adult, as a rule, suppresses it. Public functions, like theater, lectures and concerts, do not fill the place of personal social intercourse, neither does the modern formal society function of display and rivalry do aught but increase rather than diminish nerve-troubles, and suppress the social nature of man, which cannot be done without resulting in a morbid state that is productive of disease. An hour's cheerful conversation per day with congenial friends will be a great factor in maintaining health.

Too much and too little work are both harmful. I think there are comparatively few people in nearly every occupation and class of life who are injured by overwork. There are many who are doing a reasonable amount of mental and physical exertion who are ill, not from that

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cause, but from worry and anxiety. People often flatter themselves by thinking their ill-feeling is due to overwork, when, in reality, it is caused by worry. It may be stated as a rule that if the mind or any organ of the body be used for any other purpose than that for which it was created, impairment of health will take place. The mind is not for worry; that is an unnatural use, and is a cause of sickness. Many are ill because they do too little or no work, but give themselves up to "killing time" for amusement. Useful work is necessary to health. Many men rapidly decline after they retire from business.

I will call attention to a few of the problems that relate to the preservation of health that require attention and the aid of a physician in their solution.

1st. What will be the physical effect, not only upon themselves, but their progeny, of such a large percentage of women giving up domestic for public life?

2nd. Who should be prohibited from marriage?

3rd. Should coition be performed except for procreation? If so, how frequently?

4th. At what age should the child begin school life?

5th. Has not the work of the schools been increased to such an extent that it is a menace to mental and physical development?

6th. Would it not be for the girl's best physical, and future mental, growth if she were taken out of school for one year at the age of puberty?

7th. Health-boards give most of their attention to the cause and prevention of infectious diseases. Should they not devote more attention to the causes of neurotic disorders, especially those that exist in the schools, and make records of their observations so that eventually valuable deductions might be drawn from such records?

8th. The tenement-house problem in the densely populated sections of large cities, especially the ones occupied by those whose earnings are small, has always been a serious one, although much in a sanitary way has been accomplished. Now, however, that transportation facilities have been so greatly increased and perfected and the cost so much lessened in time and money, may it not be utilized to make it possible for very many to leave these parts of the city for homes more remote, where they may live in cottages and in an environment more conducive to health? The small increased cost of travel will be more than balanced by the better and cheaper homes and the less number of days lost by sickness.

9th. One of the greatest purifying agents is the direct rays of the sun; they have no way of ingress to many tenement buildings.

There are occupations that require night as well as day-work,

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others where the work, even in day-time, is done in artificial light, thereby preventing those so engaged from obtaining the benefit that comes from being in the sun.

Not only is this true of miners, but of hundreds of workers in the large cities. Every worker should be allowed an opportunity to spend on an average at least three hours of every twenty-four in daylight, either outdoors, or in rooms where the direct rays of the sun may enter. Basements should not be used for salesrooms, for manufacturing purposes, nor for working-rooms. This custom of working in artificially-lighted places is strongly entrenched; it will cost money to change. But what if it does? There should be such an awakening of public sentiment that the individual who puts money against health and life should be made an outlaw.

10TH. "Vice is a monster of such hideous mein, that to be hated needs but to be seen; but, seen too oft, familiar with his face, we first endure, then pity, then embrace."

The Chicago fire occurred, and neighboring cities contributed ready supplies to relieve physical distress. The Johnstown flood destroyed several hundred lives, and the President of the United States presided at a meeting called to raise funds to palliate the distress of the surviving victims of the disaster. After the recent volcanic catastrophe where thousands were killed and other thousands left in distress, Christendom with commendable generosity quickly sent abundant supplies to that stricken people. But the number who lost health and lives by these historical calamities is small as compared with the number injured and killed by that physical destroyer, alcoholic beverages. The fire, the flood, the volcano, startling because of their sudden manifestation, rouse humanity to united action to relieve the physical suffering they produce,—to devise fire-proof buildings, to construct stronger dams, and to renewed scientific study of volcanic action to prevent their recurrence. But this alcoholic health-and-life-destroyer, beside which the above-mentioned calamities are etiological pigmies, the one that impairs in the user every vital organ and correspondingly reduces his recuperative power, is allowed to go on without a united protest from the medical fraternity, the professed conservators of the health of mankind. When I read in scientific books and see evidence of the injurious effect of alcohol on the human organism and know how little effort physicians make to suppress its use, I cannot but feel that ordinances prohibiting spitting in public places, counting the bacteria on telephone transmitters, the introduction of individual communion cups, and other similar efforts are but puerile attempts to try to protect mankind.

Alcohol is one of the greatest causes of impaired health and loss of

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life in this country today. How to prevent its use as a beverage is a sanitary question to be answered.

11TH. Syphilis and gonorrhea need but to be mentioned to recall repulsive ulcers, infectious discharges, suffering wives, often childless because of husbands having one of the above-mentioned specific diseases, or the mothers of children with syphilitic dyscrasia, a contributing cause of many deaths and predisposed to physical affections that often result in years of suffering. It is unnecessary before this audience to dwell upon the frequency of these diseases and their injurious effects upon mankind. Some radical measure should be adopted to reduce the number of cases. The most common cause is illicit coition. In a progressive city in this country there was held a meeting for men. The audience numbered many hundred, and was made up of men from the various vocations of life, doctors, lawyers, ministers, business men, mechanics and laborers. All in the audience who never had illegal sexual congress were requested to rise. Thirty-five arose. This was too great a tax on the faith in humanity of one of the assembly, who cried out, "Thirty-five liars present." The quotation from Pope that I just read is true. How may this most common cause of specific disease be removed? Answer: Require physicians by law to report to the state attorney all cases of gonorrhea and primary syphilis under their care, with severe penalties for failure to do so, and make illegal coition a criminal offense.

12TH. Examine very thoroughly the infant. If it is sick or has a malformation it should of course be relieved by the means best adapted to the individual case. It is a serious mistake to dismiss the case with the statement that it will outgrow the trouble. It is true that certain manifestations may disappear, but they are followed by other evidences of deep-seated trouble. On the other hand, I think physicians have gone too far in their efforts to have all school-children examined by representatives of the various specialties. Any teacher who has sense enough to teach school has judgment enough to know when a child requires medical attention. Then is the time to obtain it. It is a mistake to instill into the child-mind the thought that he is a little, delicate, easily-deranged body, predisposed to physical ills from every wind that blows. Better send the boy outdoors in the morning, wakeful, with a full stomach and a clean body, hoping he will come back hungry, dirty and sleepy from the effects of rough play and an occasional fight with his companions. Girls to the age of twelve years require very little, if any, different management. The former method is the too-much-doctor supervision method; the latter, one of the best for promoting physical development.

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THE INFLUENCE OF SCHOOL LIFE UPON THE MENTAL AND PHYSICAL DEVELOPMENT OF THE INDIVIDUAL

JULIA HOLMES SMITH, M. D.
CHICAGO

The consideration of the topic assigned to me brings a realizing sense of the grave responsibilities of the educators of the country. The strange thing, to my mind, is, at first thought, that since male and female created He them, and that the father and mother are alike responsible, not only for the births, but for the evolution of character in each individual child begotten, that the school-boards appointed in different cities and towns are, with few exceptions, all men, and to the shame of the appointers be it spoken that the offices of school trustees are many times filled with men who are put there either to pay a definite political debt, or with the hope that such trustees may be used to the advantage of the appointer.

In my judgment, the successful board of trustees is made up of at least one-third women, for the reason that the feminine mind is more closely in touch with the needs of the growing child and is able to suggest the proper methods in discipline, the wise choice of school-sites, and the routine of school training. I say one-third should be women, for since there are in our minds the three divisions—intellect, sensibilities, and the will, I am ready to confess that the sensibilities ordinarily dominate the feminine mind, and that we need, as balance, the hard-headedness and business tact of clever men.

The first point of interest is necessarily the housing of the children during school life, and it goes without saying that the best shape for a school-room should be oblong, and windows only on one of the longest sides, for the very obvious reason that cross-lights are always injurious to the eyes, that many of the spectacled youngsters whom we meet in our streets are the victims of imperfectly lighted school-rooms. I would have these windows reach as high as the ceiling of the room, and there should be a double window which, during the winter, will serve to economize heat, keep out noise, and, with judicious use, help ventilation. The arrangement of seats in a semi-circular fashion is, in my opinion, most undesirable. The child should sit with the left side nearest the window, thus preventing any shadow upon book or writing, and I would certainly have the sill of the window full five feet from the floor. If any of you have ever been in a school-room which was defectively lighted you will remember how many of the children were stooping over their

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desks in order to lessen the distance between the books and the eye, thus causing the eyes to converge; in this way the muscular strain put upon the eye causes the antero-posterior axis of the eyeball to be elongated, and myopia develops. In some of the school-rooms imperfect lighting leads to the use of artificial light, which, of course, interferes with the perfect condition of the atmosphere, and pallor, restlessness and headache result. The air should certainly come into each room from the outside in the amount of 40 to 100 cubic meters to every scholar. I believe in ventilating fans, in large chimneys, in windows so arranged that they will come down from the top, and thermometers in different parts of the room, which should be kept regularly at 70° F. I have often thought that in order to develop the character and teach the pupils the importance of fresh air, it would be a good plan, as a mark of honor, to give one child the care of the ventilation of his schoolroom as a reward of merit, and to another the duty of regulating the heat, according to these thermometers, for character grows in proportion to the amount of responsibility put upon the individual, and as the teacher's duty is to make of our children good citizens, it goes without saying that the evolution of the idea of personal responsibility is an important factor in the curriculum.

Another important matter in school life is proper seating of the children, and that can only be had at the expense of considerable money. In our country each child has a right to say to himself, as did Louis XVI., "*L'etat, c'est moi,*" and as an organization, social or civic, is as strong as the weakest link, the child in school has a right to a seat which shall be neither too high nor too low, allowing the firm placing of the foot upon the floor and the erect carriage of the trunk, so avoiding disturbance of the circulation in the first instance, and stupidity with the headache caused by the bending over of the head in an uncomfortable position.

There should also be arrangements made for shorter hours in our primary schools and in the high schools and higher grades of the grammar schools, plans made for the pupils to have a hygienic lunch. Nine-tenths of the cases of indigestion and of ache which we discovered as physical examiners of the high-school graduates were directly traceable to cold lunches, excess of pie, and fancy condiments eaten at noon.

I may seem unduly anxious concerning the environments of our school children, but when we realize that over one-fifth of life between five and sixty is spent in school, one cannot be too careful in regard to all school appointments.

I should like to have all the floors made of hard wood which should be beeswaxed and polished and swept daily. I do not know how it may be in Cleveland, but to the shame of Chicago be it spoken, it is not an

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uncommon condition of affairs that our school-rooms are only cleansed quarterly, sometimes semi-annually. I would have the walls painted or tiled, with the coloring of some pale or subdued tint, and comparatively few pictures, such pictures of the very best type, since a child must have the faculty of observation cultivated, and variety of decoration distracts attention.

One more point in the management and building of the school-house, and that to my mind seems most important: There should be a larger provision for urinals and water-closets than is the custom in our city schools. I only need to suggest to you the many evils which may come from frequenting of such places by boys or girls in crowds. Parke, of London, declares "That urinal accommodations of at least five places for every one hundred children should be provided, and at least one water-closet for every twenty-five."

In the training of our children in the schools we are training not only the parents and citizens of the future, but our teachers, as well, and there should be the greatest care exercised in maintaining, so far as possible, perfect physical health, both in the boys and the girls. Equilibrium of the functions of the system is the normal state, and no child should be so taxed, physically or mentally, that this equilibrium should be disturbed, and the amount of intellectual labor which may be endured under fair circumstances is often exceptionally great. We know that all parts are strengthened by exercise, and fair, honest use, both of body and brain, makes the strong student, but woe to the teacher who over-taxes a child and causes both body and brain to cry out against abuse. It seems to me that there is not sufficient discrimination shown in the selection of our teachers, and that the coming race is being sadly handicapped, so far as they become victims of neurasthenic teachers. The verb "to nag" should never be in our vocabulary, and I certainly believe it had its origin from the feminine habit of fault-finding and scolding over petty things. I have in my mind now two clever boys, just ready for the high school, whose last few months have been made hideous by an experience with just such a "nagging" teacher. She never found anything right, was always hunting for something wrong. was never satisfied with work done, and yet was possessed with a Yankee conscience which forbade her to discriminate against William and Cyrus, who found themselves, to their great surprise, in the first five of their class.

I fear I tax your patience, and yet there is one more point to which it is most important your attention should be directed, and that is concerning the hygiene of school life for growing girls. In our examinations, it was the exceptional girl who reported herself with absolutely normal menstruation, and yet there were few who found it necessary to

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stay at home because of pain. When we realize that the monthly flow is a purely physiological process, that ovulation and menstruation should be painless, and there should really be a reactionary influence upon the nervous system, so developing the whole woman, the girl who has pain is far from normal. My idea is that girls, before menstruation is established, need plenty of sunshine, pleasant environments, agreeable exercise, and freedom from the pressure of appointed tasks, and the time when boys and girls should be separated in their school-life is during these years of the evolution of the sexual organism, and yet that is just when the girl's nervous energy is most taxed in our schools by coming in competition with boys. She must trudge up and down long flights of stairs for recitations, she has her music to practice in the afternoon, and must cram at night in order to be ready for the next day. If girls from the ages of eleven to fifteen could be spared this strain we should find fewer graduates of our high-schools to reject. Let us make childhood longer, and insist that the school life should not increase the number of nervous and dyspeptic invalids.

The president of the Chicago University has taken a long step backward when he plans to sequestrate the women of the University who have attained sufficient age to enter the College course, while at the same time he encourages co-education in the affiliated schools.

The arena of life offers today equal opportunities for men and women; the one requirement for any position is fitness for the work. This fitness can only be attained through education and attrition of other minds, and since God set the solitary in families, and there are few families of children all of one sex, it goes without saying that the educational opportunities should be shared equally by both boys and girls, but, at the same time, I am prepared to defend the opinion that during the three or four years of sexual evolution, education had better be pursued in separate schools.

Discussion:

Joseph T. Cook, M. D.: Dr. Smith's paper touches upon a very vital subject, and she very properly calls attention to many defects in the school life of the present day. I quite agree with her suggestion in regard to the school boards, which generally, no doubt, would be better able to fulfil their duties if there were women upon them. As an offset to this fact, however, it has been my experience, that in private schools, for instance, those which are conducted usually under the exclusive control of women, where there is a woman principal with autocratic powers, to be often shocked and grieved when I observe how impossible it has been for these same principals to grasp the one fundamental idea of school life, namely, that a tired child, with a wearied brain in the Month of May or June, after a fatiguing winter, cannot grasp new ideas, page after page, with the existence of the physical fatigue from which the child is

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suffering. More than once have I discussed this subject with teachers and with principals, and have been discouraged in observing how difficult it has been to impress upon them what Shakespeare so well knew, that a sound mind and a sound body must accompany each other, in order to obtain successful results.

Dr. Smith's remarks on the ventilation and lighting of schools bear no discussion; the truths are self-evident. A matter which bears directly upon the health of the child is the question of which she speaks, of adjusttable seats, seats adjusted to suit the height of the child. One cannot drive past a public or private school at a time when the children are leaving it without being grieved or shocked at the number of midgets, I was going to say, coming out of the school-house wearing spectacles. There must be a cause for it, and the question is, are we as physicians doing our duty in helping to discover the cause and to remedy the defect? Scolding about it will not do it. Oftentimes reasoning with the school superintendents and teachers does not accomplish the desired results. I knew a physician, one very well along in years, who ascribed as a reason for children wearing glasses at such a tender age, the fact that there are too many eye-doctors in the country; saying that, if we wanted to abolish that evil, we should exterminate some of the eye-doctors. That, of course, is not the proper argument. The argument lies in the proper use of the eyes and adjustable seats, which enable the children to adjust the focus of the eyes to their work.

As for school lunches, the very words cause a shiver to run down my spine, for I have often had described to me lunches served in some of the schools at a nominal price, and have made the same observation as regards the unfortunate nature of the food served under those circumstances, as has Dr. Smith. This is true even of private schools. The result seems to be a spoiling of the appetite in high-school pupils; they go home from school at 1:30 or 2:00 o'clock for their dinner, which they are very apt to get when it is cold and has been standing; and the result is that pupils without number have a poor lunch at twelve o'clock, no appetite for the noon meal at home, a light breakfast in the morning before eight o'clock, and by evening are fatigued in body and unable to grasp the work before them. It seems to me that the courses in some of our schools are too long, the school year extending too late into the warm weather after the enervating influences of the spring season. A school which is in session until June 20th or 25th carries the children into a season of the year when they are physically unfit to accomplish the work they are called upon to do.

In Germany the model school, to my mind, is the one called "the gymnasium," in other words, emphasis is given during that portion of the school life to physical development simultaneous with the mental and intellectual development. That, of course, is the correct method. Perhaps an equal amount of time should be given to the two methods of development, physical and mental. It seems to me that too little attention is given, even by the best of the schools, to the question of the body. I have had numerous conversations with teachers, and they almost universally make light of the matter, saying that they are employed to improve the minds of the children and not to look after their physical development. This principle seems to me to be wrong, and the sooner

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the teachers realize their duty in that line and the sooner superintendents of schools and boards of directors appreciate the fact that school life should include systematic physical as well as intellectual development, the sooner will schools fulfil their highest duty and be able to accomplish for the country what ought to be accomplished, *viz.*, the development of strong men and women with regard to both their physical and intellectual spheres.

And now a word in regard to the examinations during school life. In some states these examinations are conducted by independent boards, in New York State by a board of regents, and there is to-day, I think very properly, a strong protest of physicians and others who are interested in the school life of our children, against the depressing and disturbing effects upon the nervous organizations of school children of these special tests which are given them at stated times. There are those, and I think many of us will agree with that group of people, who distinctly insist that these examinations are the cause of much and serious nerve disturbance in sensitive children at seasons of the year when there is naturally a lack of tone in their nervous systems. If the class work for the term were taken as an average of the children in the making up of their annual standing, this nervous strain could be avoided and a great irritation be removed from the school life of to-day, which in itself is perhaps too much like the life of the President of our country, altogether too strenuous for the physical well-being of the pupils.

H. W. Pierson, M. D.: I was surprised that neither the leader nor the one who opened the discussion of this paper should present for your consideration the fact that educators have recognized for some time the evil results so intimately associated with the pernicious form of forcing knowledge upon the immature minds of our children. Chicago has been recognized as the center of the natural method for developing the mental faculties of the growing child, and the superiority of this method has received official endorsement at the hands of the Board of Education to the extent that preference is given to the graduates of the normal school in supplying positions as teachers in the public schools of Chicago. The results have been exceedingly satisfactory, and many of the evils referred to in the paper have almost entirely disappeared in the schools where the process of indiscriminate cramming has given place to the drawing out of the latent faculties through the cultivation of the powers of observation. Restraint and discipline have given place to intense eagerness for knowledge, with the result of a very material decrease in nerve exhaustion or the so-called neurasthenia incident to school life. I had hoped that the essayist would present this natural method in such a forceful manner that the members of the Institute would catch the inspiration and carry the word to their several committees, that a better day is dawning for the children of the rising generation; that the evils of antiquated plans for the building and equipment of our public schools is soon to give place to the newer, better and more rational method of creating an environment in which everything tended to the most favorable development of both mind and body through conformity to nature's laws.

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THE EFFECT OF THE USE OF TOBACCO ON THE SYSTEM OF THE DEVELOPING YOUTH

CH. GATCHELL, M. D.
CHICAGO

Some years ago an eminent countryman of ours made the statement that "tobacco is a necessity."

I am of the opinion that the late Mr. Blaine was a higher authority on the subject of the tariff than upon that of the tobacco-habit. That tobacco is a comfort and solace to those who use it, I do not deny. That it is a necessity, I seriously question. If it is a necessity for mankind, then why not for womankind? It seems to me that this question reduces the problem to its lowest terms.

If tobacco really is so great a solace to man as its *habitues* claim, then I would propose that its use be limited to unmarried men. No man who is married should use tobacco unless his wife is to enjoy a like privilege. Chocolate caramels are no adequate substitute.

But this is beside our subject.

Whatever may be said of the effects of tobacco on the mature organism, the consensus of opinion on the part of the best authorities is that it is highly deleterious to the system of the growing youth. It is charged with obtunding the mental faculties, blunting the moral sense, retarding physical development, shattering the nervous system, and seriously impairing the special senses.

Let us see what it is at whose door this indictment is laid, and let us see how well the charge may be maintained.

The weed itself calls for no description. The present inquiry is concerned only with its properties, and with the effect of the smoke of burning tobacco when inhaled. Moreover, reference will be made more especially to that form of smoking which consists in the use of the cigarette, for the reason that, in the young, it is the favorite form of indulgence. Cigarette-smoking, also, is more harmful than other forms of smoking because there is greater inclination to inhale the smoke, and greater quantities of it are drawn into the lungs and made to come into contact with the surfaces of the mucous membranes of the upper air-passages.

Tobacco-smoke contains nicotine and a series of empyreumatic products, chief of which is pyridine. In addition to this it contains creasote, hydrogen-cyanide and sulphur gases, and of carbon-dioxide, 9.3

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per cent. It was formerly taught by Vohl and Eulenberg that tobacco-smoke contains no nicotine, but this is an error. Kissling has recovered a large percentage of nicotine from tobacco-smoke.

Tobacco-smoke, therefore, owes its toxic properties to the presence of the contained nicotine, of pyridine, of the various other empyreumatic substances, as well as the carbon-dioxide.

When the smoke of tobacco is inhaled it comes into contact with the mucous membranes of the air-passages, the contained toxic agents are absorbed, they are taken into the circulation, and acting upon the nuclei of the various cells, they there exert their specific effects.

In order to apply our knowledge we must first consider the specific effect of tobacco upon the organism, and, for present purposes, more particularly upon the organism of the developing youth. That its effects are more serious in the young is not disputed. The reason for this greater susceptibility is that the cell-life of all the tissues in the young more nearly approaches the embryonic than in the adult.

The effect of tobacco upon the various tissues and organs is primarily through the medium of the nervous system. It affects both the cerebral and the spinal nerves, and also the nerves of the cerebral cortex. Its effects upon the motor nerves are seen in the resulting muscular tremor.

Its effects upon the nerves of the cortex are revealed in a dulling of the senses and blunting of the mental processes, which occur more especially in the young. For this reason it hinders the development of the nervous centers. Of the nerves of special sense, it has specific action upon the optic-nerve trunk and its distribution in the retina, where it produces a post-bulbar sub-acute or chronic neuritis, giving rise to tobacco amblyopia and amaurosis. This condition, if progressive, leads to impairment of sight and practical blindness.

But it is upon the heart that tobacco expends the action that is most disastrous. Its effect upon the heart is primarily through the medium of the vagus, which first is stimulated and later suffers from paresis, both at its center and in its distribution. But the effect is not confined to the cardiac nerves, for Allbutt is undoubtedly right in his claim that eventually the muscular structure of the heart suffers from fatty degeneration.

The condition known as "tobacco-heart" presents itself in many forms, accompanied by a great variety of symptoms. Primarily the effect upon the heart is to slow it in its action, but secondarily there may be greatly accelerated action. The characteristic condition is one of palpitation, with great irregularity of action, which may amount to *delirium cordis*. Pain, in greater or less degree, is usually present. This

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may amount but to a feeling of oppression, or it may be so severe as to create a condition of false angina-pectoris. The over-action of the heart may lead to hypertrophy, to secondary dilation, and to relative valvular lesions.

As another effect of tobacco the nutritive processes are much impaired. This may be due to the disturbances of digestion produced by the direct action of tobacco on the stomach, or it may be due to its action on the trophic centers. The result is defective growth, often found in "stunting" in the young.

What has here been stated would have but little meaning if accurate observation did not confirm the claims set forth. This is easy to do. There are now numerous instances recorded demonstrating the harmful effects of tobacco on the organism of the developing youth.

In January last physicians acting as School-Inspectors in Chicago examined one hundred young men in eleven different High-Schools for admission to the various athletic teams, in the sports of which unusual exertion is required. Out of one hundred aspirants the examining physicians rejected twenty-one. *Every one of the candidates rejected was a tobacco user.* Of the twenty-one, eighteen suffered from some form of tobacco-heart. The verdict of the examining physician in each of these cases was that the condition of the heart was such as to unfit the candidate to indulge in the exercise required by the sport. The form of tobacco used was, in fourteen instances, the cigarette. Of the rejected candidates, one admitted that he smoked from twenty to thirty cigarettes daily; another that he smoked from forty to fifty.

Of the seventy-nine successful candidates, as to the use of tobacco almost all were total abstainers, and a few used the weed only moderately.

Now, here is the other side. At the same time these examinations were made a large number of girls in the same High-Schools were examined for positions on basket-ball teams, and for other sports requiring unusual exertion. *Not one girl failed to pass!* Among the girls, in not a single instance was a heart resembling tobacco-heart found.

But observation further shows that the evil effects of tobacco in the young result not only in physical defects, as indicated in the instance of the boys of the Chicago High-Schools, but they are also responsible for mental degeneracy in various degrees and forms.

Prof. Herbert F. Fiske, Principal of the Northwestern University Preparatory School, at Evanston, Illinois, observed that among three hundred boys under his care, of those who failed in their examinations or were otherwise deficient in their studies, almost all were "cigarette fiends." His observations and statistics cover a period of several years. The result of his investigations may be expressed in this wise: Of boys

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in the highest grade of scholarship, only two per cent. were smokers, while ninety-eight per cent. were total abstainers; of the boys in the lowest grade in class scholarship, fifty-seven per cent. were smokers. As Prof. Fiske expresses it, "*The proportion of tobacco-users increases in inverse ratio to the scholarship.*"

Further evidence of a like nature comes from the superintendent of schools of Kokomo, Indiana. One thousand boys, from the first grade to High-School, were submitted to critical observation and examination by the entire corps of teachers. Over one-third of the boys were found to be smokers of tobacco, for the most part in the form of cigarettes. *In the same school-grade the tobacco-users averaged one year older than the abstainers.* The teachers made critical observation of all pupils with reference to their mental aptitude and powers of control. Opposite the names of the tobacco-users were many such entries as these: "Self-control poor;" "inattentive;" "not trustworthy;" "bad memory;" "no power of concentration"—and many other such comments.

Probably the most exact and systematic investigation of the effects of the excessive use of tobacco on the physical condition of the young was made by Seaver, of Yale. One hundred and sixty-nine young men were subjected to observation. Of these, seventy-seven were non-users of tobacco; twenty-two were occasional users, and seventy were habitual users. In one year's time the non-users increased in weight 10.4 per cent. more than the regular users, 6.6 per cent. more than the occasional users. In height the non-users increased 24 per cent. more than the regular users, and 14 per cent. more than the occasional users. In chest-girth the non-users had an advantage over the regular users of 26.7 per cent., and over the occasional users of 22 per cent. In lung capacity the growth was in favor of the non-user 77.5, when compared with the regular user, and 49.5 per cent. compared with the occasional user.

In view of facts here stated the conclusion is inevitable that the use of tobacco, whatever may be said in the case of the adult, in the young during the period of development is absolutely pernicious. It may with safety be said that its excessive use dulls the intellect, alters the moral nature, impairs nutrition, stunts the growth, causes functional and organic heart-disease, seriously affects the eyes, and in other ways contributes to physical and mental degeneracy.

With this before us the question is here submitted to this representative body of physicians, the American Institute of Homœopathy,—Is it not the duty of the individual members of the medical profession, as well as of its organized bodies, to do all in their power, by every possible means, to limit and to eradicate this great and threatening evil?

This question I submit for your consideration.

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DISCUSSION:

G. W. BOWEN, M. D.: For twenty years I have observed the effects of tobacco on young men who use it. They do not remember well, they are not reliable, you cannot always depend upon what they say. I have treated certain families for three generations, and watched results, and know of several intellects that have thus been blighted. Tobacco blunts the intellect; it stunts the body; it diminishes and lessens a man's morals; like opium, it almost makes the young man a prevaricator.

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DIET AS AFFECTING THE MENTAL AND PHYSICAL DEVELOPMENT OF THE INDIVIDUAL

ROBT. N. TOOKER, M. D.
CHICAGO

In whatever aspect we view the question of diet for the growing boy and girl, our conclusions will be more or less warped by education, personal experience, and scientific investigations, and, perhaps we might add, certain prejudices of a sentimental character.

If we approach the question from a purely scientific standpoint, we are confronted by the varying views and theories of those who advocate a purely vegetarian diet, and are wholly and strenuously opposed to meat as a food in any form.

It must be conceded that there is much to be said in favor of vegetarianism, especially for certain kinds of the world's workers.

During the growing period—the period of development—the period we are now considering, it is a very simple problem to decide as to which system is best.

The vegetarian asserts, and with many indisputable facts to justify the assertion, that in the cereals we have a sufficient amount of all the elements of nutrition—the hydrocarbons, the carbohydrates and mineral salts, enough to satisfy all of the body's needs from infancy to old age, and that the vegetable kingdom is, after all, the prime source of our animal food-supply.

It is an indisputable fact that the carbohydrates must in the nature of things be derived from the vegetable kingdom, for there alone are they to be found in any available quantity.

It is also a fact that the essential element of fat in our diet may be obtained with equal physiological advantage from either a vegetable or an animal source.

But when we come to the proteids, or the nitrogenous element of our food—that element which is at once fundamental and primordial—it is found that vegetable foods are relatively much poorer in the proteids than animal foods are.

For example:

One hundred parts of dried lean beef contain 89 parts of proteids; 100 parts of dried fat beef contain 51 parts of proteids; 100 parts of pea flour contain 27 parts of proteids; 100 parts of wheat contain 16 parts of proteids; 100 parts of rice contain 7 parts of proteids.

The comparison shows that even the fattest beef contains over three

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times as much proteid per 100 parts as wheat, and over seven times as much as rice. A comparison of other grains and meats gives about the same ratio.

Without going into a more elaborate argument, which time forbids, we must reach the conclusion that if we simply want to feed and develop muscle, we can do so, and do it fairly well on a vegetable diet. But we must discriminate between muscular strength and what is understood by the word energy.

Muscles do their work upon carbohydrates, which are the characteristic constituents of vegetable food; but the brain and the nervous system—the sources of energy—require nitrogen, which can only be obtained in a concentrated and eligible form from animal sources.

If proteid food be regarded as a nervous food—and it is so regarded, the world over, among scientific investigators—a diet which is rich in this element will make for intellectual capacity and bodily energy, and it is not without reason that the more energetic and progressive races of the world have, from time immemorial, been meat-eaters.

There are many other points of difference between the foods derived from the two kingdoms, but the principal—the chief differences—have been thus briefly outlined.

But can science alone, and unaided, answer the questions involved in practical dietetics, especially during the development period of life?

Science, it is true, has aided us immensely, and this fact is conceded; but, while science may aid us in forming a judgment when we are in doubt, we must, after all, appeal to the court of last resort, the court of experience, for final decision.

With all due respect to that grand army of patient investigators into the realm of scientific physiology, it is only when the deductions of the laboratory are endorsed by experience that they can be made to pass current with thoughtful people.

For example, W. Mattieu Williams, in his admirable treatise on "The Chemistry of Cookery," tells us that "Welsh rarebit" is far more digestible when properly prepared than raw cheese; that nuts and raisins eaten after a hearty dinner promote digestion, and do not retard it; that the reason why certain wines are habitually served with certain dinner-courses is because these varieties of wines best affiliate with the courses of fish and meats and game, and when properly selected by an experienced chef, they not only promote good cheer but good digestion also.

But practical experience knew all this before Prof. Williams was born.

Science only endorses experience, and tells us in scientific language the why and the wherefore. Few, if any, edible and enduring dishes

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have been invented in the chemist's laboratory. Most, if not all, of our substantial and adequate dishes have been evolved from experience, practical experience, in the kitchen and over the cooking-range.

Everybody knows, or is supposed to know, that fresh-made bread is not as easily digested as stale bread. Experience teaches that. But science explains why, and clinches the argument so that a child can understand it.

For example, fresh bread offers greater resistance to the digestive juices owing to its tendency to form doughy masses, because it contains too much water, which should be allowed to evaporate before the bread is eaten; then, again, the diastase, or ferment, which all cereals possess in greater or less quantity, and which the miller who grinds and bolts the wheat cannot wholly eliminate, must have time to act on the flour of the bread to change the starch of the bread into dextrin.

In new-made bread and biscuit there is no time for this diastatic action, so that if thus eaten it is almost like eating raw wheat, and unnecessary work is thrown on the digestive organs. Dry bread, with the water largely evaporated, crumbles into smaller particles, which are easily acted upon by the saliva and the pancreatic juice.

In most cases of dietetic discussion science is in harmony with experience and experience with science. But I repeat, science cannot stand alone. It endorses, and corrects, but does not originate. Scientific feeding did not produce a Lincoln, a Grant, a McKinley, or a Roosevelt, and no amount of scientific experiment will produce their equal.

To carry the argument into the range of morals, it is highly improbable that any sort of diet, per se, would produce a man like Washington, the one man who could not tell a lie. So, after all, we are brought back and put face-to-face with the fact that science has done but little for the growth of our American youth except to explain things. It is true, science, especially at the present day, is most active, but largely in the direction of commercialism. Its most recent achievement has been a compressed food tablet which can be carried in the vest pocket, and when swallowed will take the place of a dinner of many courses.

The country is flooded with artificial foods which are only the disguised ghosts of real foods. A certain Michigan town or hamlet is not satisfied if it does not turn out a new cereal food or substitute for food at least once a week, each one containing a little less nutriment and a larger return to the interested stockholders.

What are grape-nuts, granose, and the almost interminable list of artificial flubdubs, as compared with old-fashioned cracked wheat, oatmeal (of the old kind), wheaten grits, and corn-meal mush?

These old-time foods made soldiers brave, and farmers' boys strong; made statesmen, patriots and philosophers, while these artificial sub-

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stitutes make dyspeptics and weaklings. These much-advertised products of a pure commercialism may deceive dyspeptics and make them temporarily happy in a way, but these emasculated grains, of whatever name or wherever made, will not do for the growing boy or girl, who need brown-bread, entire-wheat flour, and such breakfast-foods as our fathers and grandfathers ate.

In the hope that I might gain some pertinent facts or some new light on this subject, I have carefully gone over the dietary of the leading university boat-crews. Surely here, if anywhere, we ought to find results in this interesting study, especially as these crews have for many years been under the scrutiny of such able men as Atwater, Bryant, Sherman and others. Harvard, Yale and Cornell have repeatedly made changes in their diet-lists, but with small results, either practical or scientific. They all taboo tea and coffee, but allow beer or Bass' Ale in moderate quantities, and beef-tea is given as a stimulant just before racing.

Just why tea and coffee, which are natural stimulants, are substituted by brewer's slops is a mystery. It is beyond me. The fact that no superiority of action and no uniform success has attended the most rigid study of dietetics in this connection but leaves the question where it was in the beginning. At least it remains at present sub judice.

Thompson, in his work on "Practical Dietetics," quotes Prof. I. W. White to the effect that "An ordinary farm table, with its mid-day dinner and early tea, will rarely offer anything which should be excluded from a rational training-diet as it is at present understood." If from this farm table we eliminate hot cakes, pastry, and fried meats, we have very nearly an ideal athletic diet.

In conclusion, let me say that the secret of a correct diet, whether during the period of development or subsequently, is to use all of nature's bountiful provision, but to use all things in moderation, and with due regard to the organs which have to do with digestion and assimilation.

Whatever we eat or drink has to undergo transformation before it can enter definitely into the organism and become blood and bone, brawn and brain. Time must be given for this elaboration, hence there must be suitable intervals between meals.

We cannot ask the stomach to work at a time when the brain seeks rest. Late suppers and dinners interfere with rest and are invariably harmful.

In a word, we must use the experience not only of ourselves but of those who have gone over the road before.

We should eat those things which we like and enjoy, rather than those which are distasteful, even though endorsed by authority the most

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high, and we should eat what we eat at suitable intervals in order to give the digestive organs their eight hours of solid rest.

This is, to my mind, the law and the gospel of proper living.

DISCUSSION:

JOHN G. CHADWICK, M. D.: Dr. Tooker has given us a most instructive paper. We are compelled to consider well the opinion of a man of such wide experience regarding infant dietary. . .

A problem that confronts the medical profession to-day is the diet of the growing boy or girl, and its effect upon the mental and physical development. Science teaches us but little in this respect, only bringing forward a multitude of facts that are not always borne out by our personal experience. Much depends on the individual, for where one is raised on a purely vegetable diet another is not and could not be. There is no doubt in my mind that the boy or girl in the developmental period of life will do best on a vegetable diet; his mind will be clearer, he will be alert, quick and cheerful; he will have quiet, restful nights, less liable to the many reflex disturbances manifest in youth; and all this because of perfect digestion.

Mothers should be educated to the fact that the family physician knows far better than they what is a suitable diet for the growing child. Your own experience will bear this out, for you have all had cases of indigestion, with its association of nervous symptoms, brought on by the indulgence of a devoted mother or grandmother. But, you say, some children live and appear healthy in spite of mismanagement. I do not believe that these cases are well, but that their symptoms are apt to be overlooked on account of indifference on the part of the parents. No matter what the constitution of the child may be, it cannot long continue the eating of indigestible foods without producing reflex disturbances. Authorities state that the main cause of chorea in children is rheumatism. My experience, however, does not bear out that statement; on the other hand, I believe that the origin of most cases of chorea is indigestion, irregularity of meals, etc. Even after the child has got its second teeth, its diet should be restricted, for the presence of indigestible food in the alimentary tract at any time is productive of reflex nervous disturbances. Gastric disorders in the school boy or girl are responsible for two-thirds of the cases of eye-strain.

J. E. GILMAN, M. D.: The diet of a child should be regulated according to the necessities of the case. In an orphan asylum in France they tested the effect which diet would have in the care of their children. Those children who were robust, full of animal life, and as full of mischief as an egg is of meat, they put on a mild, non-irritating, non-stimulating diet, containing its due proportion of the three elements necessary to make a perfect food of the farinaceous and mild type, while those children who were weak, vacillating and imperfect of impulse and purpose, the "putty" children, were put on a stimulating diet, meat and heavy food. The effects were considered quite remarkable in remedying some of these deficiencies and moderating the excesses of boisterousness in the children. Hufeland, who wrote a book on "The Art of Prolonging Life," has put the theory of the diet, I think, as perfectly as any writer of which I know. He commences

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with the infancy period, then takes childhood, and so on, puberty and old age, and gives the special type of food required. For an infant, milk is the proper food, because it is non-irritating; the nervous system is so easily disturbed and upset that if you give anything in the way of a stimulant, or anything in the way of exciting food, it is sure to upset the nervous system and make myschief. With the growing child you must supply the food which contains the largest amount of histogenetic material, the material to build up the organism. Every day we see children starved in certain proportions. Some of the tissues are lacking in their proper nutrition; the proper material has not been supplied, or if supplied, there has been no way of taking it up. When they gain adult life, then comes the need for force, the food required to make force, not so much to build up the organism in the rapidity with which it was in the growing youth, but to supply waste, and after middle life, and when the time of going down begins, then stimulation to some extent comes into the daily or occasional dietary; and he concludes with this aphorism, that "Milk is wine for babes, and wine is milk for old people."

Robert N. Tooker, M. D.: I will only take a moment, Mr. Chairman. While I was preparing this paper, I was reminded of a letter which I read from the father of a family who had been for two years in Europe. The father left Berlin, and shortly after he left the son, twenty-two or twenty-three years of age, was stricken with appendicitis. He went to a hospital in Berlin, where the chief surgeon and, I think, the surgeon in charge, had a world-wide reputation for their success in the treatment of appendicitis, surgical and otherwise. He informed his mother that he was going, and said, "You come to see me, mother, in two days." On the second day after the operation the mother went to see him, and got there about the lunch hour. On a table by the bedside he had spread out for his noon lunch raw ham, bologna sausage, a mug of beer and some sauerkraut. She sent for the surgeon in charge and said, "Do you really mean to give this patient such diet as that after so serious an operation? I am an American," she said; "in our country a patient like that would have toast and tea, farina and milk." The doctor raised his hands in holy horror, rolled his eyes and said, "Mein Gott, madam, I would not feed a sick dog on that." Now, how can I explain it? I must say that this whole matter of diet is to me somewhat an enigma. Here are these people in that hospital, and the hospital is full of them, being operated upon every day and getting well, and yet they live on food that would seem to be the most hetrodox to us who are all the time engaged in general practice. You see children that you cannot kill with sausage and mince pies, and, again, children die who are fed on ambrosia, so to speak. How is it? I do not know. Back of the constitution, back of the child, there is something more than diet. While we have, in a general way, some ideas about scientific feeding, and have reached certain conclusions, they are upset every day with facts that we cannot controvert. Sometimes in thinking of this question I say, "Let the boy and the girl have the run of the larder, to do as they please." I do think that nagging a child, putting him under restrictions, saying "You shall have so many meals a day, at such-and-such an hour,"

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is all wrong. Give the child plenty to eat; you know that an infant will throw up an excess of food: so will an older baby, a baby that goes to school. If he gets too much, he will be sick. But this "nagging" him and saying you must do so-and-so, according to our ideas, I think a mistake. I have in mind a little patient simply being starved to death by the rigid dietary that it is on. I saw the child at a friend's house the other day, and it was simply ravenous, ready to eat almost anything. It is a mistake. The child should have some leeway, and there should be some flexibility about our rules; we should not make a Procrustean bed of the dining-room table, and say that every child shall eat just so much at such a time, no more and no less.

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SOME CLINICAL, THERAPEUTICAL, SANITARY AND UTOPIAN IDEAS ABOUT CLOTHES

CLARENCE F. BARKER, M. D.
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The human race, save for some hairy coverings supplied by nature, was once accustomed to nakedness, and tailors and dressmakers did not exist, even in imagination. Today, all human offspring, at birth, is as naked as ever. But the nurse hustles us into our artificial coverings of cotton, or silk, or wool, whether we protest or not—and generally we do protest, and that right lustily—and thenceforth we are victims of clothes.

The natural antipathy of young children to clothes—their delight at being left naked, as occasionally they are for short periods; their unaffected joy at finding their anatomy free from garments—help to show that the wearing of clothes is unnatural, a product of man's ingenuity, and necessary only because of social conditions into which we are born and over which we have but limited control.

The Bible makes the beginning of the use of artificial coverings for the body an effect of the coming of the knowledge of good and evil into the world. But we suspect that the knowledge of evil therein recorded may have been a knowledge of clothes, and nothing more. For what more evil thing could have come to a race of innocent beings than a knowledge that would compel them forever to hide beneath artificial coverings, always to be obliged to wear garments of dead, and therefore decaying, animal and vegetable matter, and thenceforth to ignore, excepting for face and hands, the full uses of the beautiful and perennial envelope provided by nature.

Certainly the habit of wearing artificial coverings for the body, however important it may seem, is not necessary to man's physical well-being. It is an incident of the growth of our civilization, and by no means an essential cause of that civilization.

It has long been known that exposure of the naked body to direct rays of sunlight is a therapeutic measure of great value, and we all know the beneficial effects of sunbaths in the treatment of the sick. Surely, the good derived from exposure of the body to sunlight, air and earth are easy to find. The casual observer finds them in the thousands returning to the cities each autumn, with bronzed faces and limbs, and new life-impulses evident in every movement. The physician finds them in the effects of pure air, out-of-door life and sunshine in his desperate

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cases of illness sent to the country, or upon an ocean voyage, or perhaps in some weakly child for whom he has prescribed a pile of sand, sunlight and scanty clothing.

There is a village in Austria, near the Adriatic, where the "nudity-cure" is practiced. The debilitated go there and in the costume of Adam expose their persons to the air, the sun's rays and the rain. A hat and short trunks only are allowed. The sexes are separated. Baths, massage, gymnastic exercises and games are indulged in, and a strict vegetarian diet completes the cure.

The most vigorous specimen of health and strength and immunity from disease the writer has ever known was a man born and reared upon a farm in one of the wildest portions of Maine. He spent his waking hours in the open air, at the hardest sort of work; but no amount of exposure or physical abuse made him ill, or even tired. Until he was of age, and had left his father's farm to live elsewhere, he wore very scanty clothing upon body and limbs, and no head-coverings at all, and seldom any shoes. His contact with the outside world caused him to adopt ordinary garb, but he always asserted that clothing was exceedingly uncomfortable to him, and that his enviable physical condition was due to the hatless, shoeless and half-naked way in which he spent his early years.

But facts are one thing and conclusions another. We do not wish to excite apprehensions concerning our intentions, so we beg a little further indulgence while proceeding along this line of thought, promising at the end to set forth some very practical and entirely modest conclusions. If asked to enumerate articles of clothing especially detrimental to health we would perhaps begin with tight-fitting garments, including hats, and shoes, and all close-fitting apparel worn about the waist. Or, we might start with a discussion of the relative healthfulness of materials of which garments are made. Points of attack are numerous, so let us begin with the masculine hat.

The term "masculine" is here used because women seldom wear anything tight about the head, so do not suffer from baldness to any extent. But when women adopt masculine headgear a little more commonly we predict a great increase in the number of feminine baldheads, and a proportionately brisk demand for artificial hair. Life insurance companies do not, as yet, include baldness among disabilities involving extra risk, but sooner or later they will do so, for exposure of the unprotected scalp to drafts of air in public places is a fruitful source of catarrh, influenza, pneumonia, and a number of other diseases.

It is safe to say that the head-coverings furnished by nature are entirely adequate and that no vain devices of mankind should have ever been permitted to supplant or destroy them.

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But if we turn from the subject of artificial head-coverings and their evil effects to inspect the sanitary condition of the "well-shod" human foot, we find matters worse. The natural exhalations from the feet are large in amount, and, owing to their habitual encasement in warm, tight coverings, decomposition rapidly takes place, and the ptomaines thus formed are partially absorbed into the system. That the system can be poisoned in this way admits of no doubt. The habitually bare foot is never a source of auto-infection, neither are clean feet, but if the whole body were commonly encased in coverings such as are used for the feet, the results would be disastrous to the individual thus clothed.

Under the present system of foot-dressings, perspiration and the poisonous products of bacterial activity can only be removed effectually by several washings per day. The process requires not only plenty of soap and water, but very frequent changes of shoes and hosiery. In no other way can exhalations be properly disposed of, unless it be by discarding foot-coverings altogether, or by the adoption of porous materials.

So the alternatives consistent with health are, bare feet, or feet more frequently washed, and dressed with clean shoes and hosiery, or else the adoption of coverings that freely admit the air.

Leather is not only non-porous, but practically non-sterilizable. It is never sent to the laundry, for very obvious reasons, and consequently it soon becomes a hot-bed of bacterial life, quickly reinfecting fresh hosiery. Indeed, shoes and stockings, and the enclosed moisture from the feet, furnish almost ideal conditions for the growth of pathogenic bacteria, these conditions being (as is well known) warmth, moisture, and a suitable culture-medium. On the other hand, sunlight, air and dryness are the chief enemies to germs of all sorts.

But perhaps no one appreciates the general sanitary condition of the human foot better than the surgeon, and to illustrate his point of view, we will quote a paragraph from a standard work on surgical asepsis. It is as follows:

"Before undertaking operations upon the feet, which, as a rule, are not washed daily by most individuals, the epidermis cannot be rendered sterile by following the ordinary rules of prophylactic disinfection. There are legions of saprophytes and pathogenic bacteria sheltered by such skin surfaces. Such parts must be prepared in the most radical manner. For at least three successive days there must be given a bath, which is to be followed immediately by thorough scrubbing with a bichloride-solution (1-500). The parts are then surrounded by a compress of aluminum acetate and covered with oil-silk. The application must remain in place until the following day, when the bathing, scrub-

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bing, etc., must be repeated. If these procedures are carried out for three days, the operation may be undertaken." (Beck.)

Minor ills, like corns and bunions, and ingrowing toenails, add testimony to what has already been said concerning the conventionally shod human foot. The frequent occurrence of septicemia and death from paring nails and corns emphasizes the malignancy of the poisons here generated.

The human foot was doubtless once beautiful and thoroughly adapted to all the uses for which it was designed. It must have been strong and healthful, and capable of meeting, unassisted by coverings, all the requirements of the animal to which it belongs, as suitable, indeed, to the needs of its owner as the foot of a lion or an elephant. But in its civilized dress it has become an object of solicitude, a shape unpleasant to behold, something likely to repel intimate acquaintance.

It was recently announced that the Empress of China had ordered her women subjects to discontinue the time-honored custom of limiting the size of their feet, and the news was greeted all over Christendom with expansive smiles and superior comments. But we believe that no civilized sovereign has had sufficient nerve—or, shall we say, enough intelligence, to announce that the corset-habit is a disgrace to civilization, and that it ought to be prohibited by law.

The corset as a device for producing physical weakness, deformity and disease has no rival, but apparently it has come to stay. We have no Empress Dowager.

But while the use of the corset represents one of the worst outrages against nature, the most injurious attempt to alter and distort the "human form divine," which has ever received the sanction of large numbers of people, it is also true that all tight-fitting garments are harmful in proportion to the importance of the structures affected, and the amount of pressure exerted. An eastern physician of our acquaintance, a man of wide and enviable repute, is so much impressed with this fact that he includes in his prescriptions the injunction to wear no tight-fitting garments of any sort. He maintains, for example—and the principle is sound—that drawers should be loose, like trousers, and undershirts as roomy as overshirts. So he requires his patients to procure necessary materials and have the loose undergarments made, since they cannot otherwise be obtained.

We spoke of some of the evils arising from the use of impervious foot-wear, and have called attention to the fact that shoes are never clean or sterile. The fact that there is no easy or practical process of sterilizing leather is an insurmountable objection to its use, or to the use of chamois or kid next the skin. There are, for example, few more foul or unsanitary garments than a kid or leather glove. It is a common vehicle

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for contagion. Of this there can be no doubt. The bare hand may be considered inelegant, we believe it is on some occasions, by those who understand—and in some countries a woman may not uncover her face, but the naked hand when exposed to the grime and dust of a great city is infinitely cleaner than a hand that is gloved. Air, sunlight and the frequent use of water will keep the skin healthy and clean. But cover the skin with a leather garment that constantly accumulates filth and is never sterilized—though the outside dirt is sometimes removed from the gloves "for looks"—and the skin and its artificial coverings soon become rich with seeds of septicemia, pyemia, and suggestions of the charnel house. But some of the objections to wearing leather next the skin apply to other materials commonly used for underwear. Wool cannot be boiled without injuring it, therefore clothing made of wool is never made aseptic in the process of washing. Moreover, wool, silk and leather all more or less effectually prevent evaporation from the surfaces which they cover. But none of these objections can be urged against cotton or linen. Garments made of the latter materials are commonly sterilized by boiling them each time they are washed; and when they are in use they rapidly absorb and quickly eliminate moisture. In fact, cotton and linen are used for surgical dressings because they possess these very properties. They admit air, promote dryness and are easily sterilized by heat, qualities of the greatest importance in any material used for garments next the skin.

In this connection it is well to remark that the open mesh linen undergarments which have recently been introduced are hygienic and very commendable. The only thing that prevents their early and wide adoption is the price. But doubtless a similar and quite as valuable a fabric will be made of cotton, notwithstanding strenuous denials from those financially interested in the promotion of the linen article.

Before closing, we desire also to call attention to the absurd and almost universal practice, in our climate, of making extreme changes in the thickness of underwear at different seasons of the year. As is well known, the majority of persons living in our climate spend but little time out-of-doors in winter. Consequently they live in what is practically a summer climate most of the year. The average temperature of residences, apartment buildings, stores, factories, steam-cars, etc., during cold weather is from 70° to 80° F. Of what particular use, we ask, are thick underflannels in an atmosphere of this temperature? They are positively injurious, and the combination reminds one of the Esquimaux village at the World's Fair. The individual swelters, and his resisting power against colds is weakened, but he slowly adjusts himself to his unnecessary coverings. Both fall and spring a great crop of colds is the direct result of blind and unthinking adherence to a foolish custom.

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The sensible way is to wear underclothing of uniform weight all the year, and to put extra warmth into out-of-door wraps. Long, warm and comfortable cloaks and overcoats meet most of the requirements for out-of-door protection in cold weather, and it seems needless to say that these should be promptly removed on going into a warm room.

Having thus briefly expressed a few ideas on this important subject, we submit the following conclusions:

(1) Clothing is unnatural and its general effects unhealthful.

(2) No radical changes toward a state of nudity are likely to occur, owing to firmly established customs, laws and prejudices. If such changes begin, their progress will be but gradual, because of the unyielding character of habits that antedate civilization and history itself.

(3) Gradual changes in this direction are desirable, and every rational effort to simplify clothing should receive prompt and energetic encouragement.

(4) We should encourage parents to let children go with bare feet, bare heads and scanty attire in summer, and under favorable conditions, invalids and debilitated persons should be encouraged to take sun-baths more frequently, and, in selected cases, the nudity-cure.

(5) Close-fitting garments of all kinds are injurious, and their use should be vigorously condemned and healthful substitutes commended.

(6) We should insist upon the use of porous, aseptic materials for use next the skin.

(7) Underwear of uniform weight should be used throughout the year by persons whose occupations are of the indoor sort. The lighter weights of underwear are preferable. Out-of-door wraps may be varied to suit atmospheric conditions. Their prompt removal when within doors will prevent needless colds.

(Department stores should adopt a free checking system for the heavy wraps of customers.)

(8) The feet should be washed more frequently, several times per day when possible, and foot-wear should be changed very often.

(9) It is well to remember that the principal treatment for baldness is prevention. This involves the use of loose head-coverings, or else none at all. The treatment should begin with infancy and continue through life.

(NOTE.—The causes for this affection which are generally accepted by dermatologists are, with few exceptions, purely theoretical and wholly irrational. Even the germ-theory will not hold—unless the microbe, when found, proves to be feminine, with the traditional endency of the sex to remove the masculine capillary adornment.)

(10) It is well to remember that many of our most cherished ideas,

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laws and customs are based on usage rather than on reason. In the matter of clothes, for example, a woman must not appear in public without a skirt (excepting at the seashore and on the stage) and a man is allowed to wear a shirtwaist (but not in a hotel dining-room or cafe).

Nevertheless the race is rapidly progressing. The first step towards any form of progress is to recognize its need.

DISCUSSION:

H. V. HALBERT, M. D.: I may say, as a prelude, that Dr. Barker is a personal friend of mine, and any personal remarks I may make I feel I have the liberty so to do. The doctor is not here to defend his paper, but I know, being a learned man, he does stand by it.

I am free to admit that during certain periods of the year I should be a strong advocate of Dr. Barker's anticlothes theory. I am confident that the idea of luxury is not enhanced. during the hottest day in July, by superfluous apparel for the sake of appearance. Of course, I can easily realize what a tirade of abuse may be heaped upon the subject matter of this paper by the avaricious tailor and the inventor of style. I know full well that a man who delights in wearing a silk hat day in and day out, summer and winter alike, will not admit that this habit is a cause of his hirsute infirmity. I have often thought I would not buy a hair restorer of a baldheaded man. This feeling may possibly be shared by the author, for he certainly does not present himself to his audience to exploit his new doctrine. Just why he should take such unfair vengeance upon me, I cannot understand. I assure you it is only to perform an unsought obligation that I present my infirmity, in that respect, for the sake of defending a theme with which I am ill at ease.

But to return to the subject of clothes; there are, of course, various kinds; some wear them for show; some for warmth; there are still a few who are influenced by a consideration for modesty. As a general thing, clothing is comfortable in the winter, uncomfortable in the summer and decidedly unpleasant in the rain. We may, of course, find lessons of physical value by tracing our ancestry back to the ape, but the most of us do not enjoy genealogical deductions from our thick skinned forefathers. Through a long series of aboriginal experiments, the idea has been developed that clothing is a good thing on general principles. It is, however, our right to consider the fact that there are certain errors in the adoption of this principle, hence there should be thoughtful consideration for the true purpose of this paper.

One of the claims put forth by those who would deny us the right of clothes, is the fact that before this habit was established, mankind was covered with hair. In some unaccountable way, clothing has supplanted this prehistoric and microbe encouraging protection. The question which now concerns us is whether we shall hold to the hair or the clothes. While the former may be more economical, the latter may sometimes be cast off with pleasure.

When we forsake the jest of this subject, we find that the author has offered us a very suggestive topic, and his essay is certainly interest-

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ing and instructive. We cannot look back, even to the day of the American Indian, without acknowledging the health of those who roamed the planes in scant attire. We are equally obliged to condemn the tyranny of fashion which has imposed upon the human physiology in many ways—from the corset to the high heel. While the spirit of decoration has been one influential motive of dress, the question of protection is probably more influential. Certainly the use of excessive clothing is purely a habit. It starts with the mother's unnatural anxiety, when she bundles and covers her child until he is exhausted, and it continues during the life of many who become hothouse factors in the physical campaign of life. Manly vigor is most pronounced when it exerts some resisting power. Whenever we deplete this factor of physical resistance, we encourage weakness and sickness. As physical decay is most observed in congested centers, so the body politic is dependent upon the man who has demanded much of his physical prowess. We find to-day that the man who furnishes the bone and sinew of business progress was the bareheaded and barefooted boy who gained this power of endurance in the country.

To preach the doctrine of no clothes, will surely meet with just opposition in this country, but objection to the superabundance of clothing may well be entertained. The custom of wearing woolen underclothing encourages unsanitary conditions and depletes the physical resistance. The only excuse for such undue protection may be given to the person who lives an outdoor life. The outer garments—regulated in accordance with weather changes—will answer for the purpose of warmth with the average person who lives in a steamheated house. The cold sponge bath and a proper amount of physical training will create more physical warmth than the thickest clothing. Experience has demonstrated this truth in many cases. Certainly a man's headgear and his foot apparel are unhygienic and exhausting. Few to-day feel the necessity of woolen stockings or the fur cap. The face and hands need no protection because they are unaccustomed to it. This shows what habit may develop, and it is an incentive to consider how much we may curtail the amount of our other clothing and thereby invigorate the natural physical power.

We have been inclined to criticise the claims of those who have proclaimed the benefits of nature's treatment of disease, and yet, if we honestly reflect on this subject, we shall be obliged to admit that the most astonishing and lasting cures have been effected through this agency. Our consumptives have been saved only by the absolute out-of-door life. Our worst cases of physical infirmity have found health as they have penetrated the forests and inhabited the prairies. The luxury of civilization has encouraged debility; the environment of the household is too often the breeding ground for disease; the superabundant clothing is too frequently the incubator of ill health. If man could put his bare feet upon the ground in the propituous seasons; if the sunlight could always find us, and if the pure air could constantly enter our lungs, life would be prolonged and health would be enhanced. The subject of the paper may seem too Utopian now, but some day it will receive the consideration it deserves.

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THE TREATMENT OF CANCER BY THE X-RAY, WITH SOME COMPARISONS WITH THE VIOLET RAY

WILLIAM HARVEY KING, M. D.
NEW YORK

The ever-broadening field in therapeutics has led the medical profession into various channels, some of which have stood the test of a ripe experience, while many more have fallen by the wayside. One of the most recent additions to therapeutic resources is radiant energy.

It has long been known that sunlight is destructive to germs of various kinds, but to produce this same form of radiancy artificially, and handle it in a way that it might be used in special forms of disease, is of comparatively recent origin; or, at least, its systematic development is recent. The sources of this radiant energy are the violet ray of the white light, and the X-ray. There is a third source which bids fair to rival these two, and that is the radiant energy which emanates from radium, a supposably new element which has recently been obtained from uranium by Madam Curre, a Polish chemist; but this radiation has not been used sufficiently to give it a definite place in therapeutics.

If we examine more closely into this subject we find that the radiant energy which possesses the power of destroying disease germs, or, in other words, that has therapeutic properties, has certain peculiarities. For instance, if we take a sunlight ray and divide it into its spectral colors, those rays which, on account of their less refractory power, are found at the red end of the spectrum, and which possess great heating properties, do not have, to a marked degree at least, any therapeutic properties. As we pass along up the spectrum scale, that is toward the end of the greatest refractory rays, we find that as the heat-rays disappear, chemical rays appear; and when we come to the extreme, the violet and ultra-violet rays, we get the maximum of chemical action of the sunlight rays. It is these violet and ultra-violet rays that have therapeutic action. If we examine these so-called therapeutic rays a little closer, we find that they possess other distinctive properties. The red and other rays at the contiguous end of the spectrum, are of a different form of vibration than those of the violet and ultra-violet rays, the latter being of a finer vibration, and are very rapid in their rate of vibration.

Following along this same line, we find as we pass up the scale of fineness and rapidity of vibration the next ray we come to beyond the violet ray, is the Becqueral ray, first discovered by Becqueral as emanating from uranium, and known now to come from radium, which, as

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stated, has been separated from uranium as an independent element. These rays possess a very powerful action on living tissue as well as on germs of various kinds. It may be that when the radium is obtained in a more pure state the radiations from this element may prove of greater therapeutic value than the violet ray, or perhaps even the X-ray.

Still further up the scale is the X-ray. The rays emanating from the excited vacuum tube and known as the X-rays, are undoubtedly the finest in amplitude, and the most rapid in rate of vibration of any known to-day. These rays also possess a great effect on living tissue and on bacteria.

Undoubtedly the most interesting point connected with this subject from a purely scientific standpoint is, how do these radiations act? What is it about them that gives them the power to destroy living tissue, and to destroy bacteria? This is a subject that might occupy many pages, and yet no conclusion be reached. It may, however, repay us to glance at a few of the many theories which have been put forward as an explanation of this interesting part of the subject.

First, the chemical theory. It is held by some that it is purely the chemical action of the rays which produces the therapeutic effect, and in proof of this theory it has been cited, that, taking the spectrum as an example, the therapeutic properties of the white light develop as the chemical qualities increase.

If, however, we were to follow this same theory to a logical ending, we would be forced to conclude that the violet ray would have much greater action on living tissue and bacteria than the X-ray, as its chemical action, as demonstrated on the photographic plate, at least, is much greater, and yet experience teaches us that a violet ray does not produce as great an effect on living tissue or on germs as does the X-ray.

And here let us inquire, do the X-ray and the violet ray act the same? This question cannot be settled with certainty just now, but I believe they do. In treating lupus vulgaris and some other forms of superficial disease with the violet ray and the X-ray, the process of cure is so similar that I am forced to this conclusion. In lupus vulgaris, for instance, both with the violet and X-ray, the tubercles dry, shrink and loosen at the edges. It would be impossible by watching the process of cure to tell which form of ray had been used. The one difference noted is that if the X-ray be given with sufficient force the process of cure is more rapid.

A second theory is that ozone is set free along the path of the ray, and as ozone is known to have great germicidal action, it has been thought that it is from this source that the therapeutic effect is produced.

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Ozone is certainly a great germicide. When we come to compare the effects of the two rays as ozone-producers, we find that the violet ray is greatest, as shown in its power to deodorize, and in the oxidation of various chemicals, yet its action on living tissue is less. With the Becqueral ray the oxidizing effect is even less than with either of the other two, but its action on living tissue, as well as on bacteria, is very great. While ozone may play an important part in the therapeutic properties of radiant energy, there must be other properties as well.

A third theory is that the great force and fineness of these rays bombard, as it were, the tissues, and thus produce destruction of tissue.

A fourth theory, which has the advantage of being scientific, is that ions are set free along the course of the ray, similar to the ions that are set free by the passage of continuous current, and that these ions act on living tissue as well as on bacteria. We know, however, that ions are set free in much greater abundance by the passage of a continuous electric current than they are by the passage of an X-ray, and have no such therapeutic properties. Therefore, if ions do play an important part, they must be of a different nature than anions and cations.

Other theories, such as the electric and magnetic, as well as many more, have been advanced, but in all there seems to be some weak spot, which is pretty evident proof that we have not as yet arrived at an entirely accurate conclusion.

Another important question is, what is the nature of the action of this radiant energy on diseased and healthy tissue? The violet ray possesses less destructive action on healthy tissue than does the X-ray. Further experiments must decide whether the X-ray's greater power over diseased germs, and its greater therapeutic value, is in the same proportion that its greater destructive action is marked on healthy tissue; but certain it is that the X-ray leads the violet ray in both respects.

The Becqueral ray also possesses marked action on living tissue as well as on germs. I have seen a case where a dermatitis was produced over the left breast from carrying a small vial of radium, hermetically sealed, in the vest pocket. This dermatitis resembled, so far as inspection could determine, the dermatitis produced by the X-ray.

The most interesting point in this connection is, why is diseased tissue destroyed and yet healthy tissue remain unaffected? Why do we not necessarily destroy one when we destroy the other? As a fact, we do not, for it is possible to destroy diseased tissue and at the same time healthy tissue may be stimulated, healthy granulations formed, and the wound healed rapidly.

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Of course, these good results are obtained only when the treatment is given with judgment, for if the power of the ray be concentrated too long upon the part healthy tissue is destroyed as well as diseased tissue. Here comes in the great judgment and skill of the operator in carrying the treatment far enough to destroy the diseased cells, and short enough to affect healthy tissue. More than ten years ago Dr. J. Ingals Parsons, of London, discovered that when certain heavy shocks of electricity were passed through cancerous tumors they would destroy the cells of the involved tissue, and not the cells of the healthy tissue. He at that time put forth the theory that, as diseased cells did not have the nerve-supply that healthy ones do, and were not so well supplied with nutrition, they had less power of resistance, and consequently were the first to be destroyed. This undoubtedly explains the action of the X-ray.

Grœoen at a recent meeting of naturalists and physicians held at Hamburg, reported having made microscopic examinations of sections of tissue treated by the X-ray with the following results: Healthy tissue was less affected, and showed fewer changes than the pathological tissue. In the latter the main degenerative process consisted of hyperemia, with marked emigration of leucocytes, formation of vacuoles, and breaking down of the epithelial cells.

When we come to the practical application of the X-ray to cancers, there are several points which should be considered, as it is only by following a prescribed technic that success is the reward. The different points which may be considered with regard to the technic are: (a) the tube; (b) the exposure; (c) the results of the exposure and the process of repair; and (d) the selection of cases and the prognosis.

(a) THE TUBE.

A general division of tubes has been made into hard and soft. By the hard tube is meant one in which the vacuum is high and requires a greater voltage of current to excite it. This kind of a tube gives off a powerful X-ray, one that is capable of great penetration. By a soft tube is meant one in which the vacuum is low. These tubes may be excited with a less intensity of current, and give off a correspondingly feeble X-ray, which is not capable of great penetration. There is no question which of these tubes to choose when the cancer is deep-seated, as the ray emanating from the soft tube does not penetrate sufficiently to produce the required results on deep-seated tissues.

A case which has recently been treated by me, illustrates how much more effective a hard tube is in treating deep-seated cancers. It was an osteo-sarcoma of the pelvic bone which was treated for ten days with only slight relief of the pain, with a soft tube, one which gave a good fluoroscopic view of the bones of the hand, but not of the chest.

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A hard tube was then substituted for the soft one, and the relief was marked from the first treatment. With superficial cancers the soft tube may be used, but I believe it is always inferior to the hard tube.

(b) THE EXPOSURE.

This is the most important part in treating cancers with the X-ray. The distance the tube is from the patient should never be less than six inches, and never more than twelve inches. If it is nearer than six inches I believe the tendency to burning is increased without corresponding benefit, and if more than twelve inches the efficiency of the treatment is lessened.

The time and frequency of the exposure is also most important. I originally treated cases three times a week, and continued the radiation from twenty to thirty minutes. I have, however, come to the conclusion that more frequent treatments, even daily, with a shorter exposure, say 10 or 12 minutes, is more effective, and that the danger of burns is not so great. The number of treatments which each shall receive must depend on the individual case. No two cases will respond precisely the same, no matter if the disease happens to be of the same nature.

(c) THE RESULTS OF THE EXPOSURE AND THE PROCESS OF REPAIR.

It may be stated as a fundamental principle that there should be no undue burning of the tissues. A little redness of the skin need not contraindicate a continuance of the treatment; in fact, I always carry the treatment to the point that a little redness is apparent, as this slight action on healthy tissue is a sure indication that the diseased tissue is being affected. This redness, however, should be carefully watched, and it will be found after a few days that the redness is apt to give place to a dark discoloration of the affected parts; the degree of this darkening of the skin depending on the complexion of the patient, being greater in brunettes than in blondes. If at any time this redness should increase and become angry looking, and there should be a tendency to desquemation of the epidermis, the treatment should be discontinued until all signs of the desquemation disappear.

In open sores that are discharging, the discharge should begin to decrease from the first, and if after a number of treatments have been given with a decrease of the discharge it suddenly increases, the treatment should be lessened, or even discontinued for a short time. The rule is to give all the radiation that can be borne without producing destruction of healthy tissue. After the operator has become experienced he will not have much difficulty so to gauge his treatments as to obviate all tendency to burns, and yet produce the desired effect on the diseased tissue.

When the cancer is internal, or even external, and the skin is not

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broken, the first effects should be relief of pain. There may develop occasional slight stinging pains, which are probably due to the radiations. I have noticed this in a few cases, but they did not seriously inconvenience the patient, and soon disappeared. The deeper-seated pains should decrease from the first. Next, the tumor should shrink in size.

When the case is one of an open sore the pains should also decrease from the first, the discharge should lessen, and healthy granulations begin to appear and increase until the surface is healed over. Infected glands are more or less affected by treatment directed to the original sore, but I have found it necessary to treat the separate nodules of infection when they are located in places where the rays do not come in contact with them.

One case I treated illustrates this fairly. It was a sarcoma of the cheek, with a large secondary nodule on the neck just below the original sore, and another enlarged gland on the opposite side of the neck. The rays given to the original sore also came in contact with the nodule underneath it, and this decreased in size, but the one on the opposite side showed no sign of decreasing until treatment was given to it direct.

(d) The Selection of Cases and the Prognosis.

This, as may be supposed, owing to the short length of time the treatment has been given, is not as yet thoroughly worked out. Rodent ulcer and epithelioma are the most easily and surely cured. Next to this is sarcoma, while carcinoma is also curable in many cases. In those cases, however, in which there is the least involvement of the glandular tissue, and where the patient presents a good general appearance, the prognosis is the best. The prognosis of internal cancers, by which I mean those deeply seated, is not so favorable as those on the surface. An open wound, of course, always makes the liability of absorption greater, and consequently makes the prognosis more hazardous, but it should by no means cause one to hesitate in using the X-ray, as some of the finest cures I have seen have been in open cancers.

In closing I wish to state that I thoroughly believe we have in the X-ray, and in other forms of radiant energy, a valuable addition to our methods of treating cancers, tuberculosis, and perhaps many other forms of disease. I recognize at the same time, that there is great danger, in our enthusiasm, to hold up too alluring hopes, and therefore lead the profession to expect more than can be accomplished. If such should become true the pendulum is sure to swing too far the other way, and for a time a really valuable therapeutic agent will be neglected. It will, however, sooner or later, right itself. I trust by conservatism and close observation that the X-ray and other forms of radiation may be spared that period of reaction.

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DISCUSSION:

J. E. GILMAN, M. D.: It is rather difficult to discuss such a paper as this, because it covers all the conditions and all the circumstances of the case so completely it leaves nothing to be said. I do not know when I have heard a dissertation upon the manner of the X-rays working which has so fully met my views. I am glad the question has come up in reference to the effect of sunlight and violet rays. The burn of the X-ray is very similar to that coming from over-exposure to the sun's rays, and the character of the skin affected by the X-ray burn is similar to that affected by the sun. The penetration of the X-ray is a point I would like to add just a word or two. There is no way of deflecting the X-ray. You can check its action, but you cannot deflect it in any way, consequently, if the X-ray is applied, it goes in a straight line until checked. One of the questions asked me repeatedly is, "Will the X-ray reach internal organs as well as external tissues? Is it as applicable as to the surface disorder?" Take a sensitized plate, place it at the back of a person, place a two-inch plank in front of the person, and a Webster dictionary in front of that, and the X-ray will pass through all of these obstructions and affect that sensitized plate just as readily as if there were no obstructions. It will produce chemical action at that distance. Now, if an X-ray is applied to an external sore it passes directly through it and reaches the parts underneath. I will explain what my theory is: The X-ray reaches internal cancers just as readily as it does the external ones. The cells of the cancer are similar to those of the original tissue, and they mimic them; that is, they are not exactly the same, and yet built after the same pattern and resemblance. They lack the ability to maintain their integrity. Either from rapid growth or from some other cause they readily tend to break down, and in breaking down are the cause of an excitant or irritating effect, of an inflammatory type. If I might use the expression, the cells act in their growth as though they were insane cells; normal cells apparently, but out of place, and, consequently, have none of the habits or the strength of normal cells. Now, in this inability of the depressed cells to maintain their integrity is a reason why they are so easily disturbed and changed by the X-ray. Another is, in the formation of ozone in the tissues and the more active oxygenation in consequence. The cause of burns I believe to be due to the velocity of impact, the force of the X-ray bombardment.

When I first began to study this thing, I was quite imbued with the idea that in cancer we had a germ as a causative effect of the symptomatology of cancer. Latterly I am becoming in doubt. I do not know but that I shall land on the other side of the camp, and think that the cancer has no germ, or if it has, it is a germ which has very little causative action in production of the diseased tissue. But that ozone produces a curative effect, I am satisfied. And there is ozone produced in the tissue; of this I am sure. I have been asked: "How is it that the X-ray can be used upon diseased tissue and healthy tissue at the same time without destroying the healthy tissue, and destroying it in the same manner it does the diseased?" Healthy tissue will bear a great deal more without injury than will diseased tissue. The eye in its normal condition bears any amount of light which when diseased

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would be positively dangerous. We have as another instance, or illustration, the manner in which chloroform acts. We have in chloroform an agent which will produce death to all muscles, but in administering the chloroform its first effect is expressed upon the voluntary muscles, and if the narcosis proceeds it will reach the involuntary muscles latterly. We may put a patient under the influence of chloroform until he is entirely oblivious without injuring him, because we do not push the drug far enough to produce paralysis of the involuntary muscles. In the same manner we can use the X-ray sufficiently long to destroy the diseased tissue, and this removes the trouble, but not applying it long enough to interfere with the integrity of normal tissues; so by these repeated short exposures we have the safe minimum effect upon the diseased tissue, to initiate desired changes. I fully indorse what Dr. King said about the use of hard and soft tubes. I believe a great many of the failures that have been met with in the treatment of these cases is due to a lack of knowledge of the effects of these tubes. When I first began to experiment with this, we did not know anything about burns. It was in the first month after the discovery of the X-ray was given to the world; we used then a tube, which Providence itself must have furnished, for in our ignorance we used to give one and two hours' exposures and did not produce burns. It was a pear-shaped tube, and presumably but few of the rays escaped as compared with the more modern tubes. Since the first month after the discovery of the Roentgen ray I have been studying and experimenting with it. I did not know it at the time, but I was the first one to make a statement as to its therapeutical value in a medical journal. These early experiments were conducted in Dr. H. B. Pratt's laboratory. It might be interesting if I were to tell you of some of these experiments as to the effects of the X-ray upon germ life. We tried the effect of these upon germ life in the test-tubes. The experiments were highly successful. In Dr. Pratt's laboratory we could kill the germs with a degree of certainty which promised great results. We felt that here was something that would have a tremendous therapeutical value in all sorts of cases. Then at the Chicago Medical College were tried the same experiments, and they reported utter failure. The bacteria seemed to like the X-rays; even to thrive upon them. Then at the Hahnemann Medical College laboratory, with Dr. Wilson and Dr. Blackmar, we tested some of the pathogenic germs. And here again we met with failure. The typhoid germ seemed to thrive upon the X-ray. I then went back to Dr. Pratt's laboratory, repeating the experiments, and the germs died. I could not understand it. I thought it must be due to the difference in the machines; for in the two experiments, in which the results were so different, in the first a static machine was used, while in Dr. Pratt's laboratory we used a powerful coil, I concluded that that must be the cause for such a difference, but latterly I have come to the conclusion that the character of the tubes must have had more to do with the results than the machine itself. We were using a pretty strong current and the tube would produce burns quite readily. We used for treatment a different tube from the one in which these tests were made. Then we tested it upon a living organism, a case of tuberculosis, a report of which I made and sent to a clinical society. A lad who had

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been the rounds of the clinics, at Rush Medical, the College of Physicians and Surgeons, and other places, the longest time given him to live by any of them was three months. I gave a very full report to the clinical society of this case, giving the differences in the condition and the differences of the bacteria in the sputum at short intervals. The lad recovered absolutely. He was killed accidentally some two years afterwards, but had entirely recovered from consumption, and was actively engaged in business. In this case were given treatments of one to two hours at a time. Then in testing different diseases, I treated cases of asthma, different skin affections, tubercular glands, enlargements of glands, and then came a case of what I believed was cancer of the liver, and that case was relieved. Then came a case of cancer of the pancreas. This is very difficult to make a diagnosis of, but fortunately I had had an experience which led me to think I could diagnose cancer of the pancreas at any time. Under treatment the cancer began to diminish, there was a return of nutrition, a lessening of the cachexia, increase of strength, improvement in the character of digestion, and the patient finally recovered. Then came some cases of tuberculous nodules, and more of the indurations in the breast, these nodules and indurations out of which cancer springs. Because a girl or a woman has an enlargement in the breast it does not necessarily follow that it is to be cancerous, but out of these grow the malignant neoplasms. Previous to the discovery of the X-ray I had so much success by the use of medicine alone in the controlling of these indurations that I had gained a confidence in the treatment of them which was only occasionally shaken in the non-malignant forms, those cases which the surgeon would hesitate to operate upon, for fear that they might be malignant, but in those in which the surgeon makes his great success, I could reach them with medicine alone, and I jumped to the conclusion that I could control all of these cases without any doubt. Then I found that some of these cases were malignant and would elude me, and go on to degeneration. Then, with the X-ray, I found that I could control them when they had long passed the period in which I would have considered it probable or even possible to do so with medicines alone. That is, with the combination of the medicines and the X-ray I could reach them long after they had passed the period where with one alone I could have controlled them.

Following these cases there came to me a case of scirrhus of so extensive a character that I told the patient I would like to try what could be done, but could promise nothing. It was a scirrhus involving the full right side of the thorax, the induration extending from the border of the ribs to the clavicle. The breast was a mass of shapeless nodules. The indurated portion was as hard as a board. There were places beginning to break down, while at least a dozen different places were discharging so freely that it required dressing every two or three hours to keep it anyway in order. The arm was swollen and the case had reached an absolutely hopeless condition from any method of treatment which had heretofore been devised. I was astonished and delighted beyond measure to find how rapidly this induration gave way and soft normal flesh took its place. In six weeks' time there was no further discharge and in four months' time the cancer had entirely

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disappeared and the patient was free from it. This woman was subject to pleurisy and she contracted a severe case of pleurisy some time afterwards, from which she died. The post-mortem was performed by Dr. Snow, the pathologist, and I requested him particularly to examine and report to me if the cancer had anything whatsoever to do with the cause of her death. He assured me that it had nothing to do with it, that the patient was entirely free from the carcinoma, and her death came from an entirely different source, and had no connection at all with the carcinoma.

This was followed by another case of a lady who was sent to me by an United States pension examiner. She was to have been operated on at the Chicago hospital for schirrus involving the right breast, which was of so extensive character that it would have been extremely doubtful whether she could have survived the operation. In this case came up a serious thing. At first there was general improvement. Everything appeared to be going on all right. All at once there sprung up a considerable degree of inflammation, and my hair stood up straight with the idea that the cancer was setting in with new vigor and vitality. There was a rapid enlargement, which finally simply broke into an abscess and discharged a great quantity of pus and very rapidly healed, leaving no trace. Then came a case which has made considerable notoriety. A hemorrhage had nearly caused death, and an uncontrollable hemorrhage might be expected at any time. It was an old type of encephaloid cancer, and after three months' treatment the trouble had nearly disappeared. I have one theory in connection with this treatment, that is that recovery is due to the building up process, the furnishing of nutrition to the cells and the activity of excretion of the sewage of the body. I can perhaps illustrate it with a case, furnishing something of the idea. Where a tissue is lacking in nutrition, or where it requires large quantities of matter for repair, if we can force the cells to absorb this nutritive matter, and use such measures or medicines as may be necessary to insure the absorption, we are in a fair way of accomplishing great results. For instance, an old lady eighty years of age fell down stairs, fracturing the neck of the femur. Prof. Shears was called in and reduced the fracture, and told the family the best to be hoped for was ligmæntous union or possibly no union at all; that the patient might be able to go about on crutches, or might be bedridden, as at her age bones once broken would unite very imperfectly. I said: "No, I think I can force that limb to take up its nutrition and repair as though it were a very much younger person." With the aid of muscle-building remedies and Calc. phos., Calc. fluor., Sulphur and a few intercurrent remedies furnishing the material so that the bone took up its growth, repair followed just as readily as though she were but twenty, and now at eighty-three she is walking about without cane or crutch as readily as though there had never been any injury. Taking this illustration of the methods I have used in the treatment of cancer, after we have the destructive process arrested we have this building-up process to follow. We must make the cells strong enough to maintain their integrity and vitality. The general tendency of carcinomas is destructive to vitality. There is an anemic condition and a lack of ability to absorb nutrition and to maintain the bodily vigor, and this

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lack of absorption and this degeneration of vitality can be met partially with medicine given internally that will force nutrition. Nutrition can be applied externally as well as internally. In cases of indolent ulcers, places in which there is very little destructive processes but lack of ability to recover, local nutrition will supply the means of growth. For instance, in cases of lupus, after the inflammatory condition subsides, the tissues are so lacking in vitality often that ulceration remains as a chronic sore. By the application of such things as Bovinine I have been able to cause a rapid improvement in the general condition, and Bovinine is one of the remedies upon which I rely greatly for the relief of these cases, applied locally. In a case that had lasted for thirty years or more, of a species of fungous growth affecting the finger, following a poisoned dissection wound, the use of lanolin within three months perfected an absolute cure.

J. P. Rand, M. D.: I would like to ask of Dr. King what has been his experience with scirrhus of the breast with the violet, or X-ray, treatment.

Wm. H. King, M. D.: With the violet ray I have had no improvement in any case of cancer yet. I have treated and treated them; in fact, we have them in the Flower Hospital, and every day we have the violet ray, thirty thousand candle-power, running from nine until two or three, but so far I have not seen any results to speak of in treating cancer of any kind with the violet ray. The good results have been limited largely to a few skin diseases, especially lupus-vulgaris. With the X-ray I have treated three cases of scirrhus in the breast in very old ladies. These cases are still under treatment. I have not yet seen one where the lump disappeared, but I have seen them where they shrunk very much in size. I have seen them where the pains were entirely relieved, although there was not much pain to start with, and in every way improved, but I repeat, I have not yet seen scirrhus disappear.

W. E. Payne, M. D.: I would like to know the effect of treatment of cancer of the uterus, cancer of the fundus, for instance.

Wm. H. King, M. D.: I have not had any experience which will lead me to make a statement along that line. I have had a little, but it was so unsatisfactory I do not like to make a statement.

J. E. Gilman, M. D.: I have had some experience in that line. I had a patient Dr. McClelland sent up a little over two weeks ago. It was an absolutely hopeless case. I told them I could not promise anything at all, but if they desired the patient could stay and take treatment for a couple of weeks, and at the end of that time if I saw any improvement I would continue the treatment, otherwise I would not. Here was a cancer involving all of the uterus, extending down into the vagina, involving the bladder and rectum so that there was difficulty in the movement of the bowels. In making a digital examination, it was only with difficulty my finger could be introduced. Within two weeks

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it has decreased so that I can insert two fingers. Instead of being hard and nodular it is patulous in a great many places. The woman is gaining in general health, she feels that she is better, her appetite is improved and her strength is improved. I had a case that was of four months' standing. An operation had been performed, the cervix removed, but the cancer involving it had gone back and involved the whole of the uterus. By examining per rectum I could feel that it was as large as an orange, and nodular. This case responded very promptly, and I sent her home with no apparent trouble. It has now been three months since I heard from her, but up to that time there had been no return. I had another case of a woman who has been gradually improving. She had a cancer that was operated upon, a portion of the uterus removed. It returned, and in a purulent form. She has complete cancer cachexia, hemorrhage to some extent, a great deal of pain. The conditions of the pain in these cases are very peculiar. In this particular case I have had a steady, gradual softening of the induration and the uterus is apparently resuming its normal condition. The woman has been gaining steadily in general health and strength. I have had several cases that were very successful and also a number that have not been so successful.

S. W. Sellew, M. D.: I wish to ask a question of Dr. King: Do you cover the parts adjacent to the cancer with tinfoil?

Wm. H. King, M. D.: It takes much more current to destroy the healthy tissue around where it is diseased than it does the diseased tissue. So I do not see that it is necessary. I do not do it any longer. I use nothing in the way of protection, except over the skin of the face, which is very sensitive, and around the eyes or edges of the ears.

S. W. Sellew, M. D.: Have you any special treatment for burn when you get one?

Wm. H. King, M. D.: So far as I have experienced, sterate of zinc has a peculiarly specific stimulating effect upon the burns. Keep it in an antiseptic dressing and apply sterate of zinc, which will relieve it. A method sometimes employed is to put the part in a very weak saline solution and pass a galvanic current through it.

T. M. Stewart, M. D.: Is there danger of burn deeper than the surface, and what is to be done in case a current is applied a good while and you then get atrophy of the muscular tissue, which I have seen reported in a case where the current was applied forty minutes and the muscles began to lose their power.

Wm. H. King, M. D.: You can get a burn underneath the surface. I have seen a microscopical slide made of a knee that was very badly burned, so much so that the leg had to be amputated. There was destruction of the blood vessels throughout the entire thickness of the knee, not as great on the side opposite the tube as on the near side. The burning effect is due to the absorption of the rays and not to the

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rays passing through. You usually get the greatest burn on the surface, however. I have seen a case where a man testing a fluoroscope for two or three minutes and then used the same tube to take a photograph for twelve minutes had his hand burned and yet did not produce a burn on the patient.

ROLAND T. WHITE, M. D.: There is one important point in this connection which I wish to bring before you, being recalled to memory by some experience with deep cancerous growths, and that is the throwing upon the absorbent system extraneous matter of a toxic nature which has to be taken care of by the lympathic system. I had a case some time ago of osteo-sarcoma involving the right side of the head, apparently affecting the frontal, superior maxillary, sphenoid and palatine bones, causing very marked exophthalmos with destruction of sight on the affected side. The pain was very severe. I had been using heavy doses of morphia and other analgesics for six months or more. The first few exposures were accompanied by marked improvement, pain and swelling diminished, exophthalmos nearly disappearing, so that the eyelid again covered the ball. This was followed in a short time by reaction, with rise in temperature, prostration, increased cachexia and weakness, proliferation of the cancer cells, distortion of the roof of the mouth and nares. The sufferer speedily succumbed and died of exhaustion due to the toxic infection. I have treated successfully a variety of forms of cancer and a number of lupus cases, but I would like to learn of the failures, with the character and location of the growth, where such failures occurred. We have been listening to the reports of successful treatment; let us learn also of the failures which led up to these successes.

We learn to improve our technique not by our successes, but by our failures.

S. H. KNIGHT, M. D.: I have a case of an old lady, eighty-two years of age, who had an osteo-sarcoma of the superior maxilla. She has been under treatment for two weeks, and there is no change in her symptoms or in the tumor. I would like to ask for any suggestions in regard to treatment. I am using a moderately soft tube, giving about fifteen minutes exposure every day, but it has now been two weeks, and I see no change at all. Have you anything to suggest in the way of a harder or softer tube, or in change of the time of exposure? The tumor has been growing about six months.

WM. H. KING, M. D.: I believe there should be a very hard tube used, and one that would make the bones look white in the fluoroscope.

H. F. BIGGAR, JR., M. D.: I would like to ask what has been your experience in regard to burns in the use of the coil and static machines.

WM. H. KING, M. D.: So far as I know, there is no difference if you use the same force of current. There is apt to be a much greater force of X-ray, I believe, with the coil, and consequently there is greater liability to burns, but I do not believe there is any difference whatever

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so far as the burn is concerned if you get the same character of rays. In fact, the electric energy is entirely transformed twice, once into the cathode-ray and again into the X-ray, so that electricity is only the excitant, and the form of manifestation has nothing to do with it.

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THE CARE OF CHILDREN AS A PREVENTIVE OF NERVOUS DISORDERS

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Chicago

It is a well established fact now that functional activity is a prominent factor, not only in the development of the various organs, but also of the nerve centers from which they derive the impulse of activity. The more delicate and minute nerve elements are at birth far from being fully developed as to form, as to chemical action, and consequently as to physiological function. These minute fundamental nerve elements are extremely susceptible during what may be termed the formative period, that is childhood and early adult life. When these elements are fully formed and have taken on themselves a stable chemical activity, their functional or physiological activity for the future is established. If the form and shape is perfectly normal throughout the nervous system, and the chemical activity also, the functions will tend to the normal at all times, and it will require strong influence to cause abnormal function.

If the shape is not fully normal throughout the nervous system some are better developed than others, or there is an irregular chemism, the functions will tend to the abnormal, and with very slight cause, or even without other cause abnormal function will ensue, and we have some form of nervous disorder.

There is in the tendencies with which human beings are born and those resulting from environment and training, a great field as yet almost unexplored, for the histologist and the chemist, as well as the physiologist.

What seem to be almost insurmountable obstacles stand in the way. The histologist is probably nearer the solution of this problem than others. The improved technique bids fair to give us in the near future some remarkable results. Bids fair to open to us a new book filled with valuable and reliable information that will help the physiologist, the pathologist, and the clinician to the solution of their respective problems. The chemist, however, can see as yet very little light ahead, and yet it is to the chemist that we must look for the greatest discoveries in the practical work of relieving or curing disorders of the nervous system. The problem as to how we can study, can learn the exact chemical changes that take place in the living active nerve tissue is the greatest obstacle to the full understanding of nervous physiology and

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pathology to-day. The new chemical methods that are as yet only theories, promise much in this direction. Many of you who listen to this paper will see chemical methods developed by which we can determine the exact chemism of the brain, in its most delicate workings.

As I said in the beginning of this paper, it is a fact that during the formation period, all activities have a profound influence in the development of the neuron, in all its aspects as well as in its metabolism. We can use this fact as a help in giving man that resisting force needed to prevent nervous disorders. By right care and training not only can the inherited tendencies to malformation, improper chemism, irregular metabolism, and abnormal formation be in a great measure corrected, but normal tendencies be made to take their place. During this formative period the normal development can be almost assured, or abnormal or irregular development fostered.

How can this be accomplished? There must first be a general uniform development as nearly as may be of every possible faculty. The physical and mental must be proportionately trained. Each child should be studied in all its individualities. The child who is mentally precocious, must be retarded in its mental development and encouraged in the physical; while the dull child may have to be pushed mentally and retarded physically. There is no question that present methods of training children must render them susceptible to nervous and mental disorders. There is far too much attention given to the mental development, far too much development of the emotional and too little to the physical.

A child should have air, sunshine, rain, snow, and exercise, and plenty of it.

One grave error in training to my mind comes from a mistake in placing the emphasis of care by parents. The tendency seems to be to emphasize constantly the protection of the child from trouble, trials, and temptations. We are apt to forget that no human being can possibly go through life without meeting these. It would seem far wiser to emphasize in the training an inherent power to overcome, to minimize the effects and influences of these trials, trouble and temptations. A trial is no greater to one person than to another except as the one is better able to meet and overcome it or combat with it.

Make a confidant and companion of the child at all times. Inspire courage in the child, yes, physical, but far more important, moral courage. Be very careful not to instill any element of fear. If the child has fear, particularly moral fear, at all well developed it cannot help being deceitful, and also having a constantly worry present.

If the child is properly trained it will be practically free from worry. It can hardly contract the worry habit. There is no more di-

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rect cause of nervous disorder than worry. A very long paper could be written on the subject of worry as an etiological factor in this class of causes.

Self control is another factor of first importance. Develop thorough self control in every man or woman and the neurologist will not be needed. I do not mean to be understood as saying that there would not be any neurological cases, but that there would be so few of them.

Self control must be taught from birth. The youngest babe may be taught first regularity of habit in its little life. It can be taught to eat, go to sleep, waken, look about and go to sleep again. It need not be taught the necessity of demanding attention from those having it in care every waking minute.

How can self control be taught? Only by firm, steady, uniform, kindly discipline. No one who does not learn to obey proper authority is capable of self control. He who has not self control is unfitted to exercise control over others. As it gets older it can be taught first by having everything about its life systematic, later to do whatever it does in a systematic way. System is simply one element in self control.

In demanding obedience of a child it is not essential or right that it should be simple blind unreasoning obedience. If there exists the confidential relations and companionship so essential to the proper care and training between parent and child, everything that is requested or demanded can be explained, or the statement made that it will be explained at a time when able to comprehend. In this way the child can be given a good and sufficient reason for each request or demand. The child should be told of all the usual temptations that are likely to come, and how best to overcome them. Both physical and moral dangers should be carefully explained and watched for. The child should fully comprehend that it can talk freely with the parent on any subject, without fear. That the parent is a constant willing companion, always ready and glad to discuss in a kindly judicious way anything good or bad that may interest the child or that can possibly influence it in any way.

The physical development must be based on the same general principle. Give the child a physical power of resistance to the tests it must undergo.

The diet, clothing, exposures to climatic influences are all to be considered carefully. So much has been written and said on these subjects that it seems entirely unnecessary for me at this time to do more than call attention to the general principle of good, wise care, that will give so healthy a body that ordinary departures from the usual routine will be resisted and cause no trouble.

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There should be liberty, but not license in eating, drinking and exercise.

There can be no doubt that the disorders of the nervous system could be reduced by these simple methods, to a minimum. Why? Simply because this line of training and care, will assist greatly in establishing correct normal neurons, will tend to produce normal metabolism, normal chemical activity, and, as a result, normal physical function.

DISCUSSION:

A. P. BOWIE, M. D.: I wish to call the attention of the members to the cause of nervous diseases in children. I think our present system of education has more to do with the development of nervous diseases, especially in children, than any other thing. If we would take our children out of school, or keep them out of school until they had some physical development, and then put them under mental training, we would have healthy children, but as it is we put the child to school as soon as it is able to learn its letters. The essayist speaks of the development of every normal part of the body, every faculty of the mind. I think we ought to keep a large part of the development of the child for the future, not develop them so quickly, and in that way we would have strong, healthy children. We know young people break down a great deal sooner than they used to, just because they are kept under this vicious educational system. I have a very hard case on hand to-day. It is a case of my own child, a little girl, ten years old. She has become very nervous and fearful, and all on account of the way she was taught in school. I went to the school the other day. It was during an examination, and there was the teacher giving out the questions, and if one did not answer, all the little arms were going up, which made me nervous to see, and certainly made the child nervous. I say we don't want to educate our children so soon. We want to keep them out of the school and let them have the rain and sunshine. Give them physical development first, and then we will have strong men and women when they grow up. It is a vital question we should talk about and put in practice, and I think that is the only way in which we can accomplish anything in the way of preventing these nervous diseases.

A. B. SPINNEY, M. D.: I think Dr. Delamater has struck the keynote that every physician should take careful cognizance of. This is, how to care for children as babes growing into childhood's years to avoid nervous diseases; not to humor the child as an infant, but to bring about careful self-control. I know, as a man of many years' experience, that the real secret of avoiding neurasthenia is self-control, and I believe that self-control should be commenced in childhood and gradually developed. The mother, herself, should first learn self-control, and I would go still farther and say to the general practitioner, when the child is in utero, he should endeavor to throw around the expectant mother the right conditions to enable her to bring forth a child which shall be born right; when born right then commence the development of that child with careful feeding, regular hours of sleep; proper kind of food, bathing and every condition necessary to avoid nervous irritation—and above

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all, do not start the child to school until proper physical development has been attained. A grandchild of mine suffered from spinal paralysis so that one limb dragged; the doctor who had the mother in confinement stated it would outgrow it. I had the mother treat the child for a year and a half, every night, with galvanism and massage; the child was given proper nutriment, and step by step has grown into perfect womanhood. All the drugs in the world would not have saved her. We should begin the treatment of these cases in the cradle, and in so doing we would avoid the nervous wrecks which occur so frequently in our school rooms.

S. H. AURAND, M. D.: In nervous children the mother has more to do with making the child nervous, or curing it of its nervousness, than the school-teacher or any other person outside, or inside of, the family; possibly, in some instances, excepting the doctor. I know a family where the children were very nervous; indeed, one of the boys was so nervous you could not get him to turn out a gas-jet at night; he would take a broom-stick and fumble around under the bed for fear there was somebody there. He would lock and relock the door time and again before he was fully satisfied that it was properly locked, and would go from window to window examining each one carefully to make sure that it was securely fastened. This boy had implicit confidence in his mother, and rightly, too, for she was a sweet character, a noble woman and a perfect mother. The child, I think, was fully impressed with all this, and, therefore, in his nervous condition, would not feel content and satisfied to go to rest at night without first laying everything before his mother that occurred during the hours of the day. I believe his nervousness was a stimulus to this frank and open confession. The complaints which were advanced about the school-teacher propounding questions too rapidly and requiring immediate answer were also issues to be met in this child's life, but the mother proved herself equal to the emergency. She would tell him that as he grew older and came in contact with the things of the world he must be prepared to meet these obstacles, that he must learn to control himself under all circumstances if he would be a strong man and able to control others, and that he had the power to do so if he would cultivate it. These words, coming from one in whom the child had faith and confidence, had their desired effect. They were nerve-soothers and nerve-stimulators, and the child would go again to school with renewed power and strength, more determined than ever to win an equal victory with others. Thus, through proper care, this child has grown to be a manly and healthy looking fellow. I believe the mother has a greater influence over the proper development of the child's nervous system than any one else.

DEWITT G. WILCOX, M. D.: To my mind one of the greatest factors in the production of nervous diseases in children is the term and yearly examinations as now held in the public schools in our country. About a year ago I began to agitate this question, bringing it before the New York State Medical Society, and gradually almost the entire public press has come to support the suggestion. If we, as practitioners, would take pains to note we would find that the greatest amount of sickness among school children occurs about the time of the term or yearly exam-

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inations. Nervous, sensitive children begin to worry so greatly over examinations that in the end their nervous systems are seriously affected, and I am inclined to think that because of this reduction of strength they are much more liable to disease, even of a contagious type, because of lessened resistance. Educators ask us if this is not the best way to test the general intelligence of the child, or, if not, what method would we suggest? That is not for us to say. As physicians it is our duty to safeguard public health, to look into every public method that may affect it, and when we detect a method that is detrimental it is our duty to stop it, whether we can offer any method to take its place or not. I noticed sometime since that the State Legislature of Ohio is contemplating the establishment of regent examinations similar to what they now have in New York state. I trust the physicians of Ohio will rise against the enactment of any such measure.

SAMUEL D. HENRY, M. D.: I just wish to call your attention to a supplementary idea that might be added to Dr. Delamater's very interesting paper. We have heard several ideas that are useful, and I heartily endorse Dr. Wilcox's remarks in regard to the school examinations, but there are many pathological points that enter into the child's condition. There is the question of eye-strain that frequently produces nervousness, care of the teeth, and other irritations of the nervous system that must be met with appropriate treatment, whether that be medicinal or hygienic or surgical.

J. H. CARMICHAEL, M. D.: Dr. Delamater's paper, it seems to me, covers this subject as well as it could be covered at a meeting of this kind, for the prevention of nervous diseases in children involves all the science of psychology, and the better part of that of education or pedagogy. There is one thing we should consider, and that is, as has been stated in the paper, the physical basis of the nervous system underlying the future of the child. The great point is, we cannot tell early enough whether the nerves are normal and the nervous system developed so the child may be placed in a school at the recognized age without injury. This, however, is always a matter of experiment, and if the child is placed in school with an abnormal nervous system it consequently breaks down. The main point seems to be that the physician should be consulted, the symptoms so far as they relate to the nervous system should be carefully looked into, and the advice of the consulting physician followed, whether the child should be sent to school early in life, or its education retarded, so as to permit of a better physical development.

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ELECTRICAL ADJUVANTS IN THE TREATMENT OF PULMONARY TUBERCULOSIS

WILLIAM H. DIEFFENBACH, M. D.
NEW YORK

With the present high ratio of mortality in pulmonary tuberculosis any agent which presents evidence of serviceability in combating the ravages of the "great white plague" deserves most careful investigation and the widest publicity. With this purpose in view I venture to present to the Institute my experience with the X-ray, the static spray, and the high-frequency current in this disease.

In the March number of the *North American Journal of Homoeopathy* a short *resume* of results accomplished up to the beginning of the year was given, and further application of electricity as an adjunct in the treatment of tuberculosis has but confirmed these earlier favorable conclusions. The scope of this paper precludes mention of the generally-accepted measures of relief in this disease, including drug therapeutics, climato-therapy, solar-therapy, hydro-therapy, dietetics and the rest-cure—this field is well covered and the respective advantages are appreciated by most students of therapeutics.

Lack of practical acquaintance with their action also excludes mention of the Finsen and other light appliances, and I will confine myself to the discussion of such treatment with which I am fully conversant and the virtues of which I have tested in actual practice.

The favorable results obtained in lupus vulgaris a few years ago directed my attention to the possible bactericidal action of the X-ray, and looking up the literature on the subject it was found that authorities seemed to differ in the premises. Koch and Pfeiffer, the eminent bacteriologists, deny that the X-ray, *per se*, has bactericidal powers. Rieder, after some exhaustive experiments, claimed that the X-rays were destructive to bacterial life, but insisted that the action of the rays within living tissues could not be determined, and that no safe deductions regarding the same could be ventured. Pratt and Wightman of Chicago were among the early investigators, and positively assert that they succeeded in destroying the bacilli associated with cholera, diphtheria, pneumonia, typhoid, anthrax and tuberculosis by means of the X-ray. The technic or apparatus of Drs. Koch and Pfeiffer (some five or six years ago) must have been inefficient, or all recent investigators are on the affirmative side of the question. Personally I have tested several fresh cultures of typhoid bacilli obtained from the Board of Health, and after

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exposure of from thirty minutes to one hour the bacilli were found immobile, and secondary cultures attempted from the tubes were unsuccessful, showing destruction of bacterial life. The preponderance of evidence forces the conclusion that X-raying is undoubtedly destructive to germ life if applied with proper technic and for a certain length of time.

Why these rays of energy act as they do remains to be explained. Of theories there are several. Some claim that the ray is caustic in character, others give the credit to the actinic rays. The exceedingly high vibratory waves are mentioned by others as the agency of destruction to the parts involved. Another plausible theory is one which ascribes the results to the electrolytic action of the ray with the setting free of nascent oxygen and ozone, the germicidal action of ozone being well-known. It is claimed that the ozone set free within the tissues along the course of the ray oxidizes the dead organic matter of diseased products from which the vegetable micro-organisms obtain subsistence, and the latter, being thus deprived of the necessary food for their maintenance, are practically starved to death. At the same time the stimulating action of the rays on tissues produces local hyperemia and increased tissue-change, with subsequent improvement in the circulation and in the resisting power against bacterial attack. In several cases in which I undertook to examine the blood after frequent X-ray and static treatments, I found that the number of leucocytes was markedly increased over the original count, so that phagocytosis within the tissue must needs be also increased, with accompanying destruction of bacterial life. All these theories are very interesting, and deserve further study and elaboration.

My first trial of the X-ray as an adjunct in the treatment of pulmonary tuberculosis was in the fall of 1900. The case was a typical one; in the second stage. Change of climate could not be indulged in for financial reasons and the prescribed hygiene, diet and remedies seemed to be unavailing. You, no doubt, have all had just such cases. The patient was surely but slowly going down-hill. Noting the frequent reiteration of cures of lupus vulgaris with the X-ray and the static spray, and considering that lupus is due to tubercular infection of the skin, it occurred to me to give this unpromising case the benefit of a trial of the X-ray, although no previous authority for its exact application was in my possession. The results, as detailed in my paper in the March *North American Journal of Homoeopathy* were most astonishing and satisfactory. Since this primary case my records show a number of additional ambulant cases, all of which, without exception, have been improved. Some are still taking treatment, the others have, as far as the physical examination and bacteriological tests go, been cured. After a few treat-

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ments the coughing spells diminish, the night-sweats cease, and with proper diet and hygiene, including efficient hydriatic methods, and, in addition, the indicated homœopathic remedy, the patients put on flesh and assume all the evidences of returning health. There is nothing in the electrical treatment which conflicts with the usual methods of treating these cases, and we as homœopathic therapeutists have the additional advantage of a scientific prescription to meet the *similimum* of the symptoms of the disease. I find that the prescriptions on my records are not confined to any one drug or set of drugs—phosphorus, mercurius biniodide, bacillinum, calcarea carbonica, sanguinaria Canadensis, and ichthyol are among those most frequently prescribed.

The technic of the X-ray treatment is quite simple. The electrical exciter which I employ is the ten-plate 30-inch static machine run by a ¼ horse-power motor, connected with the direct current of 110 volts. The tube adopted as the most efficient and economical is the Bario-Vacuum Co.'s (N. Y.) regulating tube, by means of which the vacuum may be changed at will. I usually use the tube with a high vacuum, the so-called hard tube, owing to its superior practicability and minor liability to dermatitis and burn.

After locating the seat of the main lesion by means of the usual methods of percussion and ausculation, checked off by a fluoroscopic survey, the patient's chest is bared and the tube arranged so that the platinum disc is on a level with the center of the lesion. The patient is placed from 6 to 10 inches from the tube, and the anterior thorax is exposed from 8 to 10 minutes. The position is then changed, and the posterior aspect of the thorax is treated in the same location for an equal period of time.

The patient is next subjected to the negative static spray by means of the brass-pointed electrode for five minutes, the whole of the thorax being carefully gone over, avoiding the cardiac area as much as possible. Through the operation of the machine, the room becomes saturated with the ozone, and while the treatment is going on the patient is instructed to inhale and exhale as deeply as his condition will permit, so as to exercise the lungs and absorb as much of the germicidal ozone as possible. This exercise I consider of great value in the routine of the treatment. After the treatment a rest of at least fifteen minutes to half an hour is advised before leaving the office. At the beginning, the treatments are given every other day, and, as improvement manifests itself the *seances* are given bi-weekly, and gradually diminished until weekly treatments suffice.

It must again be emphasized that the electric treatment is considered merely as one of the many aids in combating this disease. As much attention is paid to hygiene, bathing, diet and the homœopathic prescrip-

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tion as though no such valuable adjuvant had been employed. In the majority of the cases improvement is marked in a very few weeks, and it is usually progressive, although relapses have taken place and will occur. I have recently tried the high frequency electric current in a case in which progress was particularly slow. It was applied by means of a glass vacuum electrode, which I designed for application in the buccal cavity, and its application promptly ameliorated the very persistent night-cough. Several French writers in recent periodicals have placed much stress on the use of the high-frequency current in tubercular conditions and claim extraordinary success for it. As far as I have employed it, I can endorse its usefulness most emphatically. My attention was recently called to several experiments performed by Dr. J. Rudis Jicinsky, Cedar Rapids, Iowa, with guinea-pigs. A number of the animals were inoculated with cultures of tubercle bacilli;—of these one-half were treated with the X-ray while the rest were not disturbed. The animals exposed to the X-ray lived, while the unexposed guinea-pigs died of tuberculosis in short order.

In reasoning out the action of the electric currents and the X-ray in the treatment of tuberculosis, the following points can be tabulated:

1. The Psychical Action.

The application of electricity has an excellent stimulating affect on the mentality of the patients. They feel that something tangible is being done for them, and at each *seance* present the buoyant spirit so essential for successful treatment. If this comes within the sphere of suggestive therapeutics—"so mote it be."

II. The Stimulating Action.

The currents undoubtedly stimulate metabolism and improve local circulation. This statement is generally accepted and requires no further elaboration.

III. Phagocytosis.

Electricity properly applied promotes phagocytosis through increasing the number of red and white blood corpuscles, as determined by myself in a number of cases.

IV. The Bactericidal Action.

The bactericidal action of the X-ray, the static spray and the high-frequency current on local surfaces is quite generally acknowledged. What action takes place within the tissues has not been definitely demonstrated, but it has been proven that certain changes leading to the destruction of extraneous micro-organism and tissues, as against a minor involvement of the integral cells of the body, take place, as shown by microscopical section and examination of the tissues and parts affected.

I trust that this summary of my experiences in this disease will call forth abundant discussion. If the success obtained in the cases treated

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is all coincidental, and not due to therapeutic principles I shall be much surprised. It should certainly induce others to give this adjuvant in the treatment of tuberculosis an exhaustive trial, so as to definitely show its limits of usefulness. If through its application but a few additional lives can be saved, the time spent in the preparation of this paper will be amply repaid.

DISCUSSION:

J. E. GILMAN, M. D.: One point I think is especially valuable in the diagnostic properties of the X-ray. Under the X-ray you can determine the presence of the tubercles in the lungs even when you could not detect them in any other way. You may get tubercles in the sputum or you may not. The capsule may be so thick you do not get any, but you can detect their presence in the lung through the fluoroscope. You can see definitely their location, and so make a diagnosis that is perfect. From my earliest experiments it has been the ambition of my life to control consumption. And I have tested almost everything which would have a bearing in that direction. When I lectured on the germ theory of disease, I, in 1882, very soon found what conditions must be present to allow the bacillus tuberculosis to grow. It must have quiet, and any disturbance, such as increase of circulation, active oxygenation, etc., would impede or destroy it. Then when I gained the knowledge of this rapid persistence, powerful bombardment of the tissues with this formation of ozone in the tissues, I began to appreciate the value of this in a therapeutical way, and made a report to the Clinical Society in June, 1897, of the work done for the year before. In this I gave clinical evidence of the power of the X-ray over the tubercular baccilli, and I quite agree with the Doctor as to the value of it in the treatment of consumption.

J. P. RAND, M. D.: Just one thought occurs to me in connection with the germicidal effect of the X-rays upon bacteria in culture-tubes. It seems to me that it is wholly possible that these rays may destroy germs in the culture-tubes when they will not destroy them in the living tissues. The culture germs are akin to hot-house plants. The conditions for their growth have been prepared with care. Their growth is rapid The germs in the body are like the hardy plants that grow by the wayside, which it is almost impossible to destroy. I think this fact has been overlooked by our bacteriologists in testing the effect of various germicides upon different bacteria. Because an agent will destroy pathological germs in the laboratory, it does not necessarily follow that it will destroy the same germs outside. The ultimate endurance of any living tissue depends upon its previous environment. A frost that would blight a hot-house plant would hardly injure the wayside flower at all and this fact must be remembered in our application of germicides as therapeutic agents. We are all indebted to Dr. Dieffenbach for his experiments with electricity in the treatment of tuberculosis, and are exceedingly glad he has had such good results.

W. H. SIMON, M. D.: I would like to know the experience of the gentlemen in tuberculosis of the joints, and if I might ask Dr. Gilman

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if he would regard as more accurate a fluoroscope examination of a joint or a radiograph.

J. E. GILMAN, M. D.: With a radiograph you might have possibly some shadows which would perhaps change your idea of it. With a fluoroscope you can take the different positions and get a very definite idea. With a fluoroscope you have something that is before you, and it is very easy to determine the character of the trouble. In regard to the treatment, I am satisfied it is quite as amenable to treatment as lupus would be. It is of the same character. These tubercles are inflammatory, and they are encapsulated, so that it does not have a tendency to spread, and I believe it would be quite as easily reached, though perhaps a little slower in action.

WM. H. KING, M. D.: I would like to add one thing. I have had a recent experience in treating a tubercular joint with the violet ray. While the violent ray will destroy a lupus, do it nicely and quickly and without any danger of burns, without any notable inflammatory reaction, and without causing any scar, so that it is almost impossible to find where the lupus was, I have not been able to produce any effect upon tubercular joints with it, and I have had a number of cases, and very bad ones, but I have not been able to do anything upon these joints with the violet rays. With the X-rays there is a very decided improvement manifested very soon after the treatment has begun.

WM. H. DIFFENBACH, M. D.: I have nothing to add except that I have been in the position of an observer in these cases of tuberculosis for some time, and the X-ray treatment is a method which ought to have our earnest consideration, especially in those cases which we cannot send to altitudes. They ought to be helped in some way. Remedies do not do it; diet does not do it, and, leaving the old beaten paths, I concluded to try this new agency, and as a result, while I do not want to claim too much, I feel very confident that we have in the X-ray an agent which will drive away this awful plague from the face of the earth. Although it may be a mere coincidence, eighteen or twenty ambulant cases have been improved, with the exception of one case, which was a case of intestinal tuberculosis with pulmonary complication. The latter had two relapses. He would go away practically well, and probably through indiscretion would catch another cold, inhale some more germs, and when he would come to me I would find that he had re-infected himself. One case I treated for a year. He still comes to the office, but I fail to find any tubercular bacilli. As soon as I make a diagnosis of tubercular infection I commence to apply the X-rays. I use no precaution against burn. I do not expose them long enough for a burn. There is no danger if you use the proper tube and do not expose too long. Exposure is usually from eight to ten minutes, six to eight inches from the surface of the tube. Improvement in many cases seems to be immediate, and the patients are unanimous in stating that they feel lighter and easier even after the first week's treatment.

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THE CAUSATION AND PREMONITORY SYMPTOMS OF TABES DORSALIS

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My purpose in the preparation of this paper has not been to describe or discuss locomotor ataxia, a disease already well known and exhaustively depicted, but to present for your consideration a few facts which have been elicited by the careful examination of a group of twenty-six tabetics. This group is more than ordinarily valuable for several reasons. They had been gathered into one institution, where they had been under observation for periods varying from one to ten years. Their histories had been laboriously ascertained by repeated and painstaking interrogation, and every step in the evolution of the disease had been noted and described with Teutonic thoroughness. Their physical condition had been ascertained from time to time, and the changes elucidated by the most skillful neurologists in the city of New York. Racially and socially (with but two exceptions), they were identical in origin and condition. Seldom is it possible to find so large an aggregation of individuals suffering from any given disease, the facts of whose life history, pathological record and diagnosis are so far removed from reasonable doubt.

Cases of this disease are of unusual occurrence in a general practice, no matter how large it may be, and those who are in a position to see it more frequently are rarely in a position to study it satisfactorily. The complaint unfolds itself with such a provoking slowness that the patient often drifts away to some one who questions the diagnosis, or who holds out a greater prospect of relief, long before a satisfactory history can be elicited or a complete picture of the disease, as it will be, has been exhibited. Granting that this untoward event does not come to pass, that the patient remains true to his physician, he is at best but one case, perhaps commonplace, perhaps *bizarre* in the extreme. As a case, it might be a good thing to report, but alone it can never serve for a basis for much deduction or theory.

The clinic is a better opportunity, since more cases may be observed, but the allegiance of the patients is slight, their stories cannot be checked by repeated questioning and the testimony of relatives and friends and conclusions are apt to be colored by the theory in vogue in that clinic at that time. I am familiar with one clinic, for instance, from which some published statistics have emanated, and believe "that

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they ought to be carefully shaken before being taken." After one of these methods, however, the classical picture of disease has been built up, and the result is a composite, a mosaic. Here and there is the glitter of a precious stone, most of the surface is of duller and less precious material, and some parts are frankly base matter put in merely to fill up the space. As time passes and the whole surface has become dulled, it is more and more difficult to differentiate the one from the other; the hasty generalization, from scanty data, and the thoughtful conclusion, based upon a most careful study of abundant material, come to look much alike, and the one carries as much authority as the other. If, then, we can secure a reasonably large number of cases, have them under competent supervision for some years, and have one expert observer check the vagaries of another, the story told by the records can be considered reliable, and should be instructive, whether it be revolutionary or simply confirmatory of classical theories.

The record of just such a group will be briefly sketched to you today. This series comprised 26 individuals, 22 males, 4 females. Dana gives in a series of 190 cases 173 males, 17 females. Eulenberg, in a series of 149 cases, gives 128 males, 21 females. Gowers gives 10 males to 1 female. Hamilton gives a dozen women to several hundred men.

Heredity is not supposed to be a factor except as it may determine a person's nervous stability, or, as we might term it, vulnerability. No case of tabes procreates a tabetic, but a neurotic parentage has an influence in a general way. No one of this series revealed a tabetic ancestor, but one had a tabetic brother and one a probably syphilitic father. Phthisis was present in ancestors in a few cases, more often in brothers or sisters, but this appeared to be more probably a result of evident conditions than of heredity.

Etiology—Of these 26 cases 14 were, from carefully sifted statements, undoubtedly syphilitic—almost 54 per cent. Syphilis, as a cause of tabes, was first announced by Erb about thirty years ago, and he made out a percentage of 90. The pendulum of opinion has swung to and fro as time has gone on, and we have had the option presented to us of the 20 per cent (Seguin) to the "98 per cent and the other two lied" of some German authorities. Buzzard discovered 51.5 per cent. Erb and Fournier, at a later date than Erb alone, 59.8 per cent. The average of five American authorities was 41.4 per cent; Gowers, in private practice, 58 per cent, and in hospital work, 80 per cent; Dana, 60 per cent.

Oppenheim says that he *knows* of no cause other than syphilis, but *thinks* that he can remember two cases of other possible causes. The possible causes postulated have been traumatism, cold and wet; over-

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exertion in combination with the foregoing, sexual excesses and alcoholism.

Inherited syphilis has been thought, in some cases, to be the localizing cause for the production of tabes from the above strains on the general system in a person not syphilitic by personal infection.

The cases here classed include one, a female, whose status was made on very marked somatic data; the others, as I have said, were confirmed by history, personal or derived from relatives and friends. It is a notable fact, noted long ago, and true in the case which I present, that the history or signs of well-marked secondaries was often absent.

Two cases of aberrant causation and differing causation may be cited just here:

Mr. C., aet. 38; English Jew; cigarette-maker; parents lived to good old age, were healthy; one brother died of phthisis at 28. This man never had a venereal disease of any kind. His wife was operated upon in a hospital; he heard that she was *in extremis*. He ran very fast to the hospital, which was at quite a distance. She died very soon, and, overcome with grief, he wandered about for hours in the rain; he was at once taken ill with pains in the spine, probably a myelitis, was confined to his bed for some weeks and is now a complete ataxic; cold, wet, overexertion, combined with nerve shock.

Miss L.; aet. 27; single; teacher of piano. Her father had a nervous disease of which ptosis was a feature; he died at 53. She endured no hardship, nor had she ever any venereal disease. When 5 years of age she began to have abdominal pains, which have at intervals persisted. At 5½ years she fell from a second-story window, alighted on her hands, and, after a few days' shock, was as well as ever, excepting a long-lasting, intercostal neuralgia, which was not exceedingly severe, since she has forgotten which side was affected. Chlorosis at 14; menstruated painlessly at 16; began to suffer from dysmenorrhea at 20. At 17, after a severe attack of abdominal pain, while in a street car, she felt for the first time a girdle sensation. One year before this she began to have attacks of somnolence while sitting in a chair, from which she would awaken screaming. These attacks continue up to the present time. She is now in an advanced stage of tabes, with diplopia and faulty bladder and rectal control. Upon a neurotic constitution, a possible paternal syphilis, localized a spinal injury in the posterior column. Hitzig believes that tabes may arise as well after a *soft* as after a *hard* chancre.

In line with this we have the case of:

Mr. M.; 35 years old. He had the opinion of a physician, and gives evidence of having a soft chancre. After eight years he had an hepatic crisis, and developed shortly a well-marked tabes.

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Seven of these individuals had gonorrhea only, and only four denied any kind of venereal disease.

Almost all acknowledged sexual excess, and many were liberal users of alcohol and tobacco, the form of alcohol being generally beer and wine. The females were exempt from these lighter vices.

The role played by excessive exertion, by excessive venery, alcohol, tobacco and nerve-shock is, of course, the lowering of the nerve tonus, by which the nervous system is predisposed to degenerative disease and, mechanically speaking, the effects must be produced by changes in the arteries, by obstruction to the lymphatic circulation, or by a changed constitution of the blood or the lymph. In no other way can the tissues be injured or poisoned. Unhygienic surroundings or habits of life are usually supposed to be effective in producing just such fundamental derangements.

Now, these people were, with two exceptions, exclusively of the Hebrew race, and a Jew is a Jew, be he born in England or in Russia, in Germany or in Spain. When, therefore, you are studying a disease manifested in a group of Hebrew patients, you have as slight a variant for race differences to allow for as can possibly be imagined; you are studying altitudes displayed upon a plane surface; it is a dead-level of neurasthenia, and why should it be otherwise?

For ages the Jew has been forced to live in the most undesirable quarter of the city, which he called his home; he breathed bad air by day and worse by night; hedged in by laws and restrictive regulations, he was forced to earn his livelihood in the least healthful pursuits, and if he attained wealth it was from an intensity of labor and poverty of life that repelled every competitor. When wealth had been amassed its retention was precarious, and possession could minister to nothing but secret luxury, the exercise of charity, or the satisfaction of miserly greed. Rich or poor, his finer sensibilities were, and in some places still are, shocked by daily insult, and *necessary* intermarriage served to intensify parental weaknesses. Observance of the hygienic laws of Moses has been optimistically assumed to be competent to neutralize any unfavorable results of unsanitary surroundings or constantly recurring shocks to the emotions and sensibilities; but any extended experience in the larger dispensaries or hospitals would serve to emphatically negative such pleasing assumptions. The fact is that arterio-capillary fibrosis is often seen at 20, is rarely absent at 40, and a stunted development and premature senility are racial characteristics.

Bad air, scanty food, continued overexertion and constant nerve-shock will work their legitimate results, be the individual Jew or Gentile. The Jew is, however, not commonly a syphilitic, and hence the potency of other factors in the causation of tabes is made more apparent. How

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potent syphilis has been in the production of these physical degenerations I am unable to decide, but their well-nigh universal existence has been forced upon my attention.

Take my statements and deductions for what they may be worth and see how they square with the ordinary practices of the clinics.

In many clinics, and I am especially familiar with one from which many statistics emanate, it is the custom to assume the arterio-capillary fibrosis; enlarged and perceptible epitrochlear glands and nodosities on the sterno-costal articulations are sufficiently strong evidence upon which to postulate a pre-existent syphilis; *ergo,* the tabes present is syphilitic in origin, and goes into the percentage of 80 and 98 per cent, as the case may be; also, and more widely, is it held that the substantive form of emphysema is either directly or hereditarily syphilitic. From this comes again the classification of the patient in the ranks of those whose tabes is secondarily syphilitic.

In view of this, it is well known that the Hebrew race present all these stigmata much oftener than any other race, and it is just as well authenticated that they are very rarely syphilitic.

While of no great value, it is interesting to note what had been the initial symptoms. The typical order is as follows:

First—Westphal's sign (lost knee-jerk);

Second—Argyll-Robertson pupil;

Third—Lancinating pains, usually in lower limbs, but at times secondary to gastric crisis;

Fourth—Analgesias (col. of Clark), often sensation not lost, but pain appears only as a *pressure;*

Fifth—Romberg's symptom (joint-sensation abolished, not tactile alone);

Sixth—Difficult urination, or an absence of desire more than once or twice in 24 hours (always symptomatic);

Seventh—Sexual weakness or perversion, or, satyriasis or priapism, followed by sexual weakness;

Eighth—Paralysis of ocular muscles, usually the external recti. It may affect any or all muscles; never associative, but may appear in both; generally comes and goes, and at length is firmly seated—ophthalmoplegia;

Ninth—Gastric crisis of vomiting or pain, or both together;

Tenth—Spasmodic cough;

Eleventh—Paralysis of the vocal chords;

Twelfth—Trophic changes of bones and joints;

Thirteenth—Inco-ordination of locomotion. It may be at first only a stamping of the heels; first noticed by an observer and not the patient (due to trouble in the direct cerebellar tract).

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In this group they developed thus; the first symptom was:

Ocular	3;	Girdle sensation	1;
Cerebral apoplexy	1;	Alteration of sensibility in feet	3;
Cephalalgia	1;	Lightning pain	5;
Gastric crisis	1;	Intestinal crisis	1;
Spinal pains	2;	Vescical weakness	1.
Weakness in legs (all grades)	7;		

This tabulation only points out the wide diversity of *reported* initial symptoms, which probably means that one man was led to notice one divergence from health, and another a different one, because it more quickly interfered with his peculiar avocation or from a difference in mental acuteness. To show how a definite initial symptom may fail of recognition by physicians, I will quote two cases:

Mr. T.; aet. 46; American. Normal at birth and in parentage. Injured by falling against a lamp post at the age of 12, but, as he acquired syphilis at the age of 20, we will bar the traumatism as a causative factor. At the age of 30 he developed a periodical dysentery, so intractable to remedies that he for years took daily 40 to 50 drops of *tr. opii.* This dysentery was accompanied by lancinating pains in the legs, which were termed sciatic. In 1896 (ten years from the inception of the dysentery) he began to sway in motion; 1897 began to be numb in his feet; 1898 went to bed and has not been able to walk since. It took skilled physicians ten years to trace any connection between a periodical intractable dysentery with lancinating pains and tabes. In view of this, an absolute belief in the statements of patients is uncalled for. This man lost control of his bladder in 1899, in the same year developed diplopia and in 1901 was almost blind.

Another patient, Mr. M., 35 years old, had from a soft chancre hepatic crisis, with nausea and bilious vomiting, repeated at intervals of from ten days to three weeks for a long period, followed by bulbar and cranial nerve-symptoms, but no marked ataxia, for some time.

Only three of these persons, as I have said before, had initial eye-symptoms, but of course many developed these later. It is, however, very significant that none but syphilitic or soft-chancre cases ever developed cranial-nerve or bulbar symptoms; *i. e.*, symptoms in such localities where a primary syphilitic infection is prone to display its secondary effects.

A case in point is that of Mr. A.; Russian Jew; aet. 35; single; clerk; parents healthy; had ten children; one died in infancy (only one out of ten, in a Russian Jew's environment, would indicate a vigorous stock); one of cholera, at 16; one sister, phthisis, at 18. Mr. A. was not especially strong, but still was never ill, and was exposed to no especial hardship. He had a chancre in 1886, at the age of 20. He had three months' treatment by one physician, inunctions for thirty

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days, pills three months, then nine months' internal treatment by a second physician. In 1896 he was attacked by a terrible pain in the head, from which he could get no relief. His right eye began to grow dim, became blind, and in one year he lost the sight in the other also.

A very interesting question in regard to treatment has been raised. Does a mercurial treatment mitigate the disease, delay its onset, or hasten it?

I once heard a prominent neurologist make this statement, and I find it embalmed in a text-book of considerable authority. He stated that, if he ever was so unfortunate as to acquire syphilis, he felt that however much a vigorous mercurial treatment would benefit the initial infection, it would so surely hasten the possible succeeding tabes, that he would forego its employment.

The series from which I am quoting shows these facts. Those who had received thorough, or even measurably thorough, treatment developed tabes in 10.8 years. Those who had very slight treatment were seized in 8 5-6 years. Those who had slight treatment, or none at all, developed a very severe form of the trouble in from 4 to 6 years.

All these categories exclude the case of a man who thought that he had enjoyed syphilis three times and had had gonorrhea very many times. He had thorough treatment and developed tabes in four years from his last chancre, but necessarily his knowledge of the incubative period was defective; he was too busy.

My conclusions as to the teachings of this particular group of tabetics are these, and they may give us license to extend them considerably:

First—Males exceed females in liability to this disease fully 5 *to* 1, *and, very probably,* 10 *to* 1.

Second—While syphilis is a potent and preponderating cause of tabes, it is not the only one, and it is so clearly demonstrated to my mind that I should not consider a person, known generally to be truthful and upright, both as a man and as a boy, as a liar and a debauchee because he had tabes. I think also that the percentage of syphilitic causation would have been higher in a Gentile series of the same amplitude. I feel that, out of a hundred thousand (100,000) *Hebrews, more individuals are destined to become tabetic than in an equal number of persons from a race less generally affected with arterial degenerations.*

From the opinion which I have reached, and stated rather elaborately in regard to the effect of toxemias on this race, I am led to believe that among individuals of other races toxemias from various causes might produce structural changes which would predispose them

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to tabetic degeneration, in the absence of syphilis, either personal or inherited.

Third—That syphilitic tabetics tend to betray, by early cranial and bulbar symptoms, the specific origin of their disease.

Fourth—It is unfortunate that no group of equal size may be studied, whose initial syphilis has been treated by homœopathic medication, that we might draw valid conclusions as to what an extent we should be able to avert such an unfortunate sequel. The only such case that I have seen was treated by the strictest homœopathy that exists, and he developed gastric crisis (i.e., bulbar symptoms) in about 15 years. Failing this profitable field, as we look over our data we find that there is no ground for belief that in any of these cases a thorough mercurial treatment hastened the onset of tabes. On the contrary, it seems to have often delayed its onset, and, at times, beneficially modified its symptoms.

DISCUSSION:

J. RICHEY HORNER, M. D.: After careful observation I am led to believe that heredity has nothing to do with locomotor ataxia. I think a neurotic individual will be more apt to develop a condition of locomotor ataxia after a syphilitic exposure has occurred than if there were no neurotic history in the family. With regard to syphilis as a cause for locomotor I, from what I have read and what I have heard from those who have made it a careful study, am inclined to believe that syphilis is not only a very important factor in causation, but am inclined to side with our German friends who speak of the "98 per cent of cases and the other two as lies." In conversation with Professor Gowers of London, my feeling was that while he would not publish his belief that the percentage of syphilis as a causative factor in this disease is very high, he believes it to be much higher than he records in his book. Eighty per cent is a low estimate, I believe, with him, but he is so extremely conservative in what he publishes that he prefers to fix it at 80 per cent rather than say what in reality he thinks, which, I think, would be as high as 90 or 95 per cent. We must inquire in these cases not only about a *visible* chancre but about an *invisible* one. I believe there are many cases of urethral discharge which are syphilitic, due to urethral chancre. When we have a patient with locomotor who confesses he has had gonorrhea, we can make up our minds pretty conclusively that it was a case of urethral chancre, and I think that better authorities believe the same way, this accounting for the high percentage, that makes us suspect syphilis as being a causative factor. The real practical point in the paper is that the author places, as one of his first symptoms which develop, *lightning pain.* How many times a neurologist has a patient come to him with advanced locomotor and say, "Two, three or five years ago, so-and-so treated me for neuralgia or rheumatism." There is where the locomotor condition was developing, and there was where the case was curable, and it is almost criminal negligence to treat these cases in a general way, in an indifferent way, when

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they have sharp, shooting pains in the leg, in the back, in the arms, without making a careful investigation, and this is one practical point in the paper to which the general practitioner should pay close attention. I was rather surprised at the early development of these cases. It has been my experience that cases of locomotor do not develop until twelve to fifteen years after the initial sore. Whether that is the general experience or not I am not prepared to say, but that is the result of the investigation I have made in cases of hospital work and cases I have had in my private practice.

N. B. Delamater, M. D.: I want to thank Dr. Wilson for this paper. It is a paper of very great value. It shows the kind of study that should be put upon all neurological subjects. In regard to the syphilitic end of it, we always get into deep water. I am just like Dr. Horner, only I don't believe so much of it. It has been my habit, in what few cases I have had an opportunity of seeing, to go into the elements of the etiology as far as possible, and I have worked very hard on the syphilitic theory. Twenty-five years ago I believed that 99 per cent were syphilitic, but to-day I don't think it is anywhere near as large. I believe there are a large number of cases that are syphilitic, but I don't believe there are 80 per cent, and I take into account the idea of internal chancre, but I don't like to damn a man with the charge of having had syphilis simply because he happens to have tabes. My line of cases might have been different from others. There is one point that I want to call attention to, and that is that the condition in the nerve tissue in connection with tabes is not syphilitic nerve degeneration. If it is the result of syphilis there must be some germ introduced with the syphilis that produces a different kind of tissue-change from what we get in direct syphilitic nerve-tissue degeneration. Now, just how much this has to do or does not have to do with it I don't know, except this, that it has satisfied me that the essayist is right in some of the things he says in regard to treatment. I do not believe that anti-syphilitic treatment is of very great value in tabes. I do believe that the mercurial treatment, carried to the extent that it so frequently is, is actually damaging in tabes. I believe that tabes is more likely to progress with some rapidity under the mercurial treatment than without it. I have practically, in my own experience, thrown out iodide of potash and large doses of mercury in the treatment of tabes. I don't imagine I get any better results than others, but I feel very sure I have had bad results a great many times from the use of anti-syphilitic treatment, while in other nerve-tissue changes—that is, those that were, and are, straight syphilitic tissue-degenerations—I do get results, and prompt results, from the anti-syphilitic treatment. In that class of cases I do not get a multiple neuritis as a result of mercurial inunctions, while in a great many cases I am sure neuritis is the result of syphilitic treatment they have had—that is, mercurial treatment. There is a point as to whether syphilitic cases are not likely to develop in the brain first. I believe the point is well taken. I have had quite a number of cases, as I call them to mind now, in which it was the early pains in the head, or other symptoms about the head, that were developed, and these, if I can remember correctly, have been syphilitic cases.

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G. A. YOUNG, M. D.: In regard to the cause of tabes by syphilis, I would like to inquire of the essayist his views in regard to the etiology. I would like to say that Dr. Delamater's speaking of the pathological finding in tabes has brought to mind the fact that whereas in paresis over 90 per cent undoubtedly are caused by syphilis, yet the autopsies do not find any direct syphilitic lesions. They come under the head of histolysis syphilitica. Pathologists find also that, notwithstanding these cases of paresis are supposed to be caused by syphilis, in very few cases is there active anti-syphilitic treatment. Having had an asylum practice of a year and a half, I have had a great many cases of paresis, and in only one of them have I found any improvement. The general opinion, I believe, is now that tabes and paresis in the pathological findings resemble each other very closely. The character, pathology and histology of each disease is very similar, and in regard also to the etiology of paresis it might be interesting to mention in relation to the tabetic etiology, it is coming to be considered as an immediate factor between the syphilitic infection and the on-setting disease which they class as toxemia, the toxemia that is caused by syphilis, and the toxemia in itself is the direct cause of the paretic symptoms, and they are hoping on this to reveal the basis of palsy—the pathological basis of toxemia —and in support of this I have heard of a number of cases of palsy that have been improved by using a cold wet-pack, and it is a well-known fact that a cold wet-pack, employed every day for a period of three-quarters of an hour to an hour, at a temperature of 55 to 60 degrees, has a distinctly eliminating effect. After the patient has been in this for a certain amount of time, after removing the pack it has a distinctly foul odor, whether from excretions or not I do not know. It is often a stimulant to the peripheral circulation by means of the terminals of the nerve fibres, and through these terminals, of the functions of the peripheral cutaneous glands. I would like to hear from the author of the paper under discussion in regard to his views whether there is any similarity or relation between paresis and tabes.

J. E. WILSON, M. D.: Paresis, I think, is generally considered as a stage of disorganization of the different structures. The paper was merely an attempt to state the facts elucidated by examination, and not to develop details or advise treatment.

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REPORT

OF THE

COMMITTEE ON ORGANIZATION, REGISTRATION AND STATISTICS

THOS. FRANKLIN SMITH, M.D.,
CHAIRMAN

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ORGANIZATION, REGISTRATION AND STATISTICS

STATISTICS OF

ORGANIZATIONS AND INSTITUTIONS DISPENSARIES

MEDICAL SOCIETIES MEDICAL JOURNALS

HOSPITALS MEDICAL COLLEGES

BY THOS. FRANKLIN SMITH, M.D.

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ORGANIZATION, REGISTRATION AND STATISTICS

NATIONAL SOCIETIES.

American Institute of Homœopathy. Organized 1844. Not incorporated. The annual meeting was held in Cleveland, Ohio, from June 17th to 21st, 1902. President, James C. Wood, M. D., Rose Building, Cleveland, Ohio. Secretary, Charles Gatchell, M. D., 100 State street, Chicago. Number of members, 1,996; admitted this year, 159; died this year, 30. Annual dues, $5.00. Publishes its "Transactions."

International Hahnemannian Association. Organized 1880. Not incorporated. Annual meeting was held in Chicago, Ill., from June 25th to 27th, 1902. President, Timothy Dwight Stow, M. D., Mexico, N. Y. Secretary, John B. S. King, M. D., 6713 Wentworth avenue, Chicago, Ill. Number of members, 190; admitted last year, 50; died last year, 2. Annual dues, $5.00 Publishes its "Transactions." Delegates, J. Henry Allen, M. D., John B. S. King, M. D.

American Homœopathic Ophthalmological, Otological and Laryngological Society. Organized 1878. Not incorporated. The annual meeting was held in Cleveland, Ohio, from June 14th to 17th, 1902. President, C. Gurnee Fellows, M. D., 70 State street, Chicago, Ill. Secretary, Herbert D. Schenck, M. D., 241 McDonough street, Brooklyn, N. Y. Number of members, 155; admitted last year, 13; died, 1. Annual dues, $3.00. Publishes its "Transactions."

American Obstetrical Society. Organized 1885. Incorporated 1885. No meeting has been held for the last eight years, but it still exists, and hopes, at some future time, to again go on with its work. President, John Nicholas Mitchell, M. D., 1505 Spruce street, Philadelphia, Pa. Secretary, George W. Winterburn M. D., 44 Bradhurst avenue, New York, N. Y. Annual dues, $5.00. Number of members, 119.

American Association of Orificial Surgeons. Organized 1887. Not incorporated. The annual meeting is held in Chicago, Ill., in September of each year. President, Henry C. Aldrich, M.D., Minneapolis, Minn. Secretary, Ralph St. John Perry, M.D., Farmington Minn. Number of members 305; admitted last year, 5. Annual dues, $1.00. Publishes its "Transactions." Delegate, T. E. Costian, M. D.

National Association of Medical Examiners. Organized 1891. Not incorporated. The annual meeting was held in Cleveland, Ohio, in June, 1902, during the sessions of the American Institute of Homœopathy. President, Augustus Korndoerfer, M. D., 1728 Green street, Philadelphia, Pa. Secretary, Horace M. Paine, M. D., 89 North Forsyth street, Atlanta, Ga. Number of members, 100. Annual dues, $1.00. Delegate, Horace M. Paine, M. D.

Society of Homœopathicians. It has been impossible to obtain any report, as the Secretary refuses to give any.

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Surgical and Gynecological Association of the American Institute of Homœopathy. Organized 1899. Not incorporated. Annual meeting was held in Cleveland, Ohio, in June, 1902, during the sessions of the American Institute of Homœopathy. President, W. Louise Hartman, M. D., 601 Warren street, Syracuse, N. Y. Secretary, J. Wyllis Hassler, M. D., 1503 Poplar street, Philadelphia, Pa. Number of members, 115; admitted last year, 12; died last year, 1. Annual dues, $5.00.

SECTIONAL OR INTERSTATE SOCIETIES.

Interstate Homœopathic Medical Association. Organized 1894. Not incorporated. The annual meeting is held in Binghamton, N. Y., on the second Tuesday in June of each year. The semi-annual meeting is held in Scranton, Pa., on the second Tuesday in November of each year. President, Theodore Sureth, M. D., Scranton, Pa. Secretary, John B. Bates, M. D., Binghamton, N. Y. Number of members, 60. Admitted last year, 3. Annual dues, $2.00. Delegate, Theodore Sureth, M. D.

Missouri Valley Homœopathic Medical Association. Organized 1876. Not incorporated. The annual meeting is held in different places alternately in October of each year. The meeting of 1902 will be held in Lincoln. President, Phineas J. Montgomery, M. D., Council Bluffs, Iowa. Secretary, Lewis P. Crutcher, M. D., 423 Deardorff Building, Kansas City, Mo. Number of members, 200; admitted last year, 6; died last year, 5. Annual dues, $2.00.

Southern Homœopathic Medical Association. Organized 1885. Incorporated 1885. The annual meeting is held in different cities in the South, alternately, in November of each year. The meeting of 1902 will be held in Louisville, Ky. President, Susan M. Hicks, M. D., "The Grand," Atlanta, Ga. Secretary, Lizzie Gray Gutherz, M. D., 3689 Olive street, St. Louis, Mo. Number of members, 98; admitted last year, 4. Annual dues, $3.00. Delegates, Henry R. Stout, M. D., A. M. Duffield, M. D. "The meeting in Atlanta, Ga., in 1901, was well attended, and much interest manifested."

STATE SOCIETIES.

Alabama Homœopathic Medical Association. Organized 1890. Incorporated 1890. The annual meeting is usually held in Birmingham, Ala., on the third Tuesday in September of each year. President, G. G. Lyon, M. D., Mobile, Ala. Secretary, A. E. Meadow, M. D., Blockton, Ala. Number of members, 8. Annual dues, $2.00. Delegates, A. M. Duffield, M. D., Asa N. Ballard, M. D.

Arizona Homœopathic Medical Association.

California State Homœopathic Medical Society. Organized 1877. Incorporated 1877. The annual meeting is held in different cities in the State, alternately, on the second Wednesday in May of each year. The meeting of 1902 was held in Del Monte. President, E. C. Manning, M. D., Potomac Block, Los Angeles, Cal. Secretary, Guy E. Manning, M. D., Spring Valley Building, San Francisco, Cal. Number of members, 163; admitted last year, 10; died last year, 3. Annual dues, $2.00. Has published during last year "The History of the California State Homœopathic Medical Society," by J. M. Selfridge, M. D. Delegates, W. J. Hawkes, M. D., Edgar V. Van Norman, M. D.

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Colorado Homœopathic Society. Organized 1881. Not incorporated. The annual meeting is held in different cities in the State, on the second Tuesday in September of each year. The meeting of 1902 will be held in Pueblo, Col. President, J. Wylie Anderson, M. D., Steele Block, Denver, Col. Secretary, Edwin Jay Clark, M. D., Steele Block, Denver, Col. Number of members, 55; admitted last year, 8. Annual dues, $2.00. Publishes its Transactions in "The Critique." Delegates, C. F. Stough, M. D., F. H. Faust, M. D.

Connecticut Homœopathic Medical Society. Organized 1851. Incorporated 1864. The annual meeting is held in New Haven and Hartford, alternately, on the third Tuesday in May of each year; the meeting for 1903 will be held in New Haven. The semi-annual meeting is held on the third Tuesday in October of each year, at such place as is determined upon at the annual meeting; the semi-annual meeting of 1902 will be held in Meriden, Conn. President, Charles H. Colgrove, M. D., Willimantic, Conn. Secretary, Hills Cole, M. D., 926 Main street, Hartford, Conn. Number of members, 110; admitted last year, 10; died last year, 2. Annual dues, $3.00. Publishes its "Transactions." Delegates, E. H. Linnell, M. D., H. P. Cole, M. D. Published last year is "Transactions," and the "Proceedings of the Semi-Centennial Celebration of the Society." The society celebrated its Semi-Centennial celebration in Hartford on November 18th and 19th, 1901, by a two-days' meeting. At the afternoon session of the first day we had read a history of the Society, a paper on "Homœopathy in the United States, 1851-1901," by Thomas L. Bradford, M. D., of Philadelphia, one on "The Homœopathic Materia Medica," by John P. Sutherland, M. D., of Boston, and one on "Medical Colleges and Medical Education," by Pemberton Dudley, M. D., of Philadelphia. The evening session took the form of a public meeting which was very largely attended. John P. Rand, M. D., of Monson, Mass., read an address on "The Relation of the Physician to the Patient," which was followed by one on "The Relation of the Patient to the Physician," by Professor Luther, of Trinity College, Hartford. The evening's exercises closed by an address on Samuel Hahnemann, by Theodore Y. Kinne, M. D., of Patterson, N. J. On the morning of the second day papers were read on "Medical Legislation," by Hon. Charles E. Gross, of Hartford, "The Progress of Medicine in Fifty Years," by George F. Laidlaw, M. D., of New York, and "The Progress of Surgery in Fifty Years," by George W. Roberts, M. D., of New York, and "The Hospital of 1851 and 1891," by Horace Packard, M. D., of Boston. The celebration closed by a banquet in the afternoon, which was rendered unique in the annals of the Society by the presence of the President of the Connecticut Electric Medical Society, and the President and Secretary of the Hartford Medical Society, the last of whom responded to the toast of "Fraternity in Medicine." The Celebration was the biggest thing in the history of Homœopathy in Connecticut. The annual meeting of 1902 was held in Hartford. An unusually fine and distinctly Homœopathic series of papers were read. President Charles E. Sanford, M. D., gave an address on "Vital Force and its Antagonisms." Drs. H. A. Roberts, C. E. Stark, Benjamin H. Cheney, Erastus E. Case, C. N. Payne, and T. St. John contributed "A Study of the Kali Group of Drugs." T. H. Mann, M. D., read a paper on "Bacteriology;" J. T. Black, M. D., made an address on "The Dyspeptic

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Woman," and C. A. Williams, M. D., read a paper on "Chronic Arteritis." In the Bureau of Neurology H. P. Cole, M. D., read a paper on "The Nervous System in Relation to Disease," and Hills Cole, M. D., read one on "Mind and Matter." The meeting was one of the most interesting and one of the most valuable ones that has ever been held.

Medical Society of Delaware and the Peninsula. Organized 1883. Incorporated 1884. The annual meeting is held in Wilmington, Del., on the second Thursday in November of each year. President, Frank Pierson, M. D., Sixth and Washington streets, Wilmington, Del. Secretary, Clara M. Ferguson, M. D., 830 West street, Wilmington, Del. Number of members, 29; admitted last year, 1; died last year, 1. Annual dues, $2.00. Delegates, G. R. Carmichael, M. D., T. O. Cooper, M. D.

Illinois Homœopathic Medical Association. Organized 1855. Incorporated 1865. The annual meeting is usually held in Chicago on the second Tuesday in May of each year. The semi-annual meeting is held in Chicago, on the second Tuesday in November of each year. President, O. B. Blackman, M. D., Dixon, Ill. Secretary, Edgar J. George, M. D., 801 Marshall Field Building, Chicago, Ill. Number of members, 400; admitted this year, 29; died last year, 3. Annual dues, $2.00. Delegates, A. L. Blackwood, M. D., Thomas C. Duncan, M. D., Wilson A. Smith, M. D., Herman M. Pierson, M. D. "The last annual meeting was one of the most successful meetings in the history of the Society; there was an attendance of 342. The Association is very active in the furthering of causes to our interests. We have set aside the sum of two hundred dollars for the use of the Chicago Committee on Drug Provings, and have a strong Legislative Committee, including the Executive Committee of the Association, who have the authority to draw upon the treasury of the Association to meet all necessary expenses."

Indiana Institute of Homœopathy. Organized 1867. Incorporated 1867. The annual meeting is held in Indianapolis on the fourth Thursday and Friday in May of each year. President, F. C. Stewart, M. D., 129 East Ohio street, Indianapolis, In. Secretary, H. H. Baker, M. D., Muncie, Ind. Number of members, 130; admitted last year, 10; died last year, 2. Annual dues, $2.00. Delegates, Orange S. Runnels, M. D., J. Augustus Compton, M. D. "The number of members given includes only those who have paid up; there are probably twenty more, whose names might be added, who come irregularly to the meetings, and pay up when they attend, but do not appear to be very active at the present time."

Hahnemann Medical Association of Iowa. Organized 1869. Incorporated 1873. The annual meeting is held in Des Moines and Sioux City, Iowa, alternately, on the second Tuesday in May of each year. President, H. A. Humphrey, M. D., Lake City, Iowa. Secretary, E. Richards Ames, Rolfe, Iowa. Number of members, 200. Annual dues, $3.00. Publishes its "Transactions."

Homœopathic Medical Society of the State of Kansas. Organized 1869. Incorporated 1870. The annual meeting is usually held in Topeka, Kan., on the first Tuesday in May of each year. President, Charles Lowry, M. D., Topeka, Kan. Secretary, Clay E. Coleman, M. D., Kansas City, Kan. Number of members, 45; admitted last year, 5; annual dues, $1.00. Delegates, S. C. Delap, M. D., Charles F. Menninger, M. D. "The usual an-

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nual meeting was held in May, 1902. Work looking toward securing control of medical service in one of the Insane Hospitals is under way."

Kentucky State Homœopathic Medical Society. Organized 1866. Incorporated 1886. The annual meeting is held in Lexington and Danville, alternately. President, R. L. Carrick, M. D., Georgetown, Ky. Secretary, J. T. Bryan, M. D., Louisville, Ky. Number of members, 100; admitted last year, 15. Annual dues, $2.00.

Hahnemann Medical Association of Louisiana. Organized 1872. Not incorporated. The annual meeting is held in New Orleans, La., in January of each year. President, Charles J. Lopez, M. D., 111 Bourbon street, New Orleans, La. Secretary, Charles R. Mayer, M. D., 919 St. Charles avenue, New Orleans, La. Number of members, 22; admitted last year, 5. Annual dues, $3.00. Delegates, Gayle Aiken, M. D., Charles R. Mayer, M. D.

Maine Homœopathic Medical Society. Organized 1867. Incorporated 1867. The annual meeting is held in different cities in the State, alternately, on the second Tuesday in June of each year. The meeting of 1902 was held in Biddeford, Me. President, L. A. Stewart, M. D., Brooksville, Me. Secretary, Cora M. Johnson, M. D., Skowehagen, Me. Number of members, 66; admitted last year, 3; died last year, 1. Annual dues, $2.00. Delegates, R. J. Wasgatt, M. D., W. J. Renwick, M. D.

Maryland State Homœopathic Medical Society. Organized 1875. Incorporated 1875. The annual meeting is held in Baltimore, Md., on the third Tuesday in May of each year. The semi-annual meeting is held in different cities in the State, alternately, on the third Tuesday in October of each year. President, George H. Wright, M. D., Forest Glen, Md. Secretary, John A. Evans, M. D., 22 North Carey street, Baltimore, Md. Nubmer of members, 65. Admitted last year, 5. Died last year, 2. Annual dues, $2.00.

Massachusetts Homœopathic Medical Society. Organized 1840. Incorporated 1856. The annual meeting is held in Boston, Mass., on the second Wednesday in April of each year. The semi-annual meeting is held in Boston, Mass., on the second Wednesday in October of each year. President, Winfield S. Smith, M. D., 845 Boylston street, Boston, Mass. Secretary, Frederick L. Emerson, M. D., 50 Hancock street, Dorchester, Mass. Number of members, 345; admitted last year, 19; died last year, 4. Annual dues, $5.00. Publishes its "Transactions." Delegates, John P. Sutherland, M. D., J. Herbert Moore, M. D., Geo. B. Rice, M. D., Frank C. Richardson, M. D., Henry E. Spalding, M. D.

Homœopathic Medical Society of the State of Michigan. Organized 1869. Incorporated 1869. The annual meeting is held in different cities in the State, alternately, on the third Tuesday in May of each year; the meeting of 1902 was held in Mt. Clemens, Mich. President, Alfred Graham, M. D., Detroit, Mich. Secretary, J. H. Ball, M. D., Bay City, Mich. Number of members, 140; admitted last year, 14; died last year, 1. Annual dues, $2.00. Delegates, Daniel A. MacLachlan, M. D., M. C., Sinclair M. D.

Minnesota State Homœopathic Institute. Organized 1867. Not incorporated. The annual meeting is usually held in Minneapolis.

Missouri Institute of Homœopathy. Organized 1876. Not incorporated. The annual meeting is held in St. Louis and Kansas City, Mo., alternately, on the third Tuesday in April of each year. President, L. E. Whitney,

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M. D., Carthage, Mo. Secretary, Lewis P. Crutcher, M. D., Kansas City, Mo. Number of members, 225; admitted last year, 6; died last year, 1. Annual dues, $1.00. "The last meeting, held in St. Louis, was. numerically, financially and enthusiastically, the best one which has been held in several years."

Nebraska State Homœopathic Medical Society. Organized 1873. Incorporated 1883. The annual meeting is held alternately, in Lincoln and Omaha, Neb., on the second Thursday and Friday in May of each year. The 1902 meeting was held in Omaha. President, Everett B. Finney, M. D., Lincoln, Neb. Secretary, E. Arthur Carr, M. D., Lincoln, Neb. Number of members, 200; admitted last year, 5. Annual dues, $1.00. Delegates, Delizon A. Foote, M. D., Everett B. Finney, M. D.

Homœopathic Medical Society of the State of New Hampshire. Organized 1852. Incorporated 1853. The annual meeting is held in Concord, N. H., on the first Wednesday in June of each year. President, R. V. Sweet, M. D., Rochester, N. H. Secretary, Channing Bishop, M. D., Bristol, N. H. Number of members, 73. Admitted last year, 3. Annual dues, $1.00. Delegates, Charles E. Dodge, M. D., Frank O. Worcester, M. D.

New Jersey State Homœopathic Medical Society. Organized 1854. Incorporated 1870. The annual meeting is movable, but is usually held in Newark and Trenton, alternately, on the first Tuesday in May of each year. The semi-annual meeting is held alternately in different cities of the State of New Jersey. President, James Franklin Ackerman, M. D., Asbury Park, N. J. Secretary, Isaac Cooper, M. D., Trenton, N. J. Number of members 150; admitted last year, 15; died last year, 4.

Homœopathic Medical Society of the State of New York. Organized 1850. Incorporated 1862. The annual meeting is held in Albany, N. Y., on the second Tuesday and Wednesday in February of each year. The semi-annual meeting is held in different cities in the State, alternately, in the autumn of each year, usually in October. President, John L. Moffat, M. D., Dean street, Brooklyn, N. Y. Secretary, De Witt G. Wilcox, M. D., 597 Elmwood avenue, Buffalo, N. Y. Number of members, 457; admitted last year, 17; died last year, 12. Annual dues, $3.00. Publishes its "Transactions." The Society is in a very healthy and prosperous condition.

Homœopathic Medical Society of the State of Ohio. Organized 1864. Not incorporated. The annual meeting is held in different cities in the State, alternately, on the second Tuesday in May of each year. The 1902 meeting was passed, on account of the meeting of the American Institute of Homœopathy in Cleveland in June. President, Thomas M. Stewart, M. D., 704 Elm street, Cincinnati, Ohio. Secretary, Andrew B. Nelles, M. D., 198 East State street, Columbus, Ohio. Number of members, 239; admitted last year, 6; died last year, 1. Annual dues, $3.00. Publishes its "Transactions." Delegates, James C. Wood, M. D., Charles E. Sawyer, M. D.

Homœopathic Medical Society of the State of Oregon. Organized 1876. Incorporated 1876.

Homœopathic Medical Society of the State of Pennsylvania. Organized 1866. Incorporated 1896. The annual meeting is usually held in Philadelphia in September of each year. The semi-annual meeting is held in different cities in the State in the month of March of each year. Presi-

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dent, Robert P. Mercer, M. D., Chester, Pa. Secretary, Edward M. Gramm, M. D., 1833 Chestnut street, Philadelphia, Pa. Number of members, 348; admitted last year, 23; died last year, 4. Annual dues, $5.00. Publishes its "Transactions." Delegates, Augustus Korndoerfer, M. D., J. L. Peck, Charles Mohr, M. D.

Rhode Island State Homœopathic Medical Society. Organized 1850. Incorporated 1850. The annual meeting is held in Providence, R. I., on the second Friday in January of each year. Quarterly meetings are held in Providence, R. I., on the second Fridays in the months of April, July and October of each year. President, J. H. Bennett, M. D., Pawtucket, R. I. Secretary, Martin S. Budlong, M. D., 604 Westminster street, Providence, R. I. Number of members, 51; admitted last year, 6; died last year, 1. Annual dues, $5.00. Delegates, H. M. Sanger, M. D., George B. Peck, M. D.

Homœopathic Medical Society of South Dakota. Organized 1893. Incorporated 1893. The annual meeting is held in different cities in the State, alternately, in the month of June of each year. The 1902 meeting was held in Sioux Falls, S. Dak. President, A. C. Clark, M. D., Aberdeen, S. Dak. Secretary, F. L. Mitchell, M. D., Artesian, S. Dak. Number of members, 35; admitted last year, 6. Annual dues, $1.00.

Homœopathic Medical Society of the State of Tennessee. Organized 1875. Incorporated 1890. The annual meeting is held, alternately, in different cities in the State, but at no regular time; the time and place is determined at the last previous meeting. President, T. E. Enloe, M. D., Nashville, Tenn. Secretary, Edward Harper, M. D., Knoxville, Tenn. Number of members, 40. Annual dues, $1.00. "Rigor mortis has set in; society is in a dying condition; no meeting has been held during the last two years."

Texas Homœopathic Medical Association. Organized 1884. Incorporated 1884. The annual meeting is held in different cities in the State, alternately, in the autumn of each year, usually on the second Wednesday in October. President, W. D. Gorton, M. D., Austin, Texas. Secretary, Julia H. Bass, M. D., Austin, Texas. Number of members, 40; admitted last year, 10. Annual dues, $1.00. "The Association, under the new Examining Law, nominates eighteen candidates for membership in the Examining Board, from whom the Governor of the State appoints nine, as a Homœopathic Examining Board, to serve for a period of two years."

Vermont Homœopathic Medical Society. Organized 1854. Incorporated 1858. The annual meeting is held in Montpelier, Vt., on the third Wednesday in May of each year. The semi-annual meeting is held, alternately, in different cities in the State, on the third Wednesday in October of each year.

Hahnemann Medical Society of the Old Dominion. Organized 1880. Not Incorporated. The annual meeting is held in different cities of the State, in the month of November of each year. The meeting of 1902 will be held in Newport News, Va. President, W. P. Moncure, M. D., Fairfax, Va. Secretary, Harry B. Baker, M. D., 1 East Grace street, Richmond, Va. Number of members, 20; admitted last year, 2. Delegate, George F. Bagby. "The society was in a moribund condition for some time, but at a meeting held in Richmond last November we succeeded in reviving it and hope that in the future we will be able to give you regular reports of what we are doing down here. I be-

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lieve that there had been no meetings held for the two or three years preceding. Homœopathic physicians are very scarce in this part of the country, and it is very difficult for them to attend the meetings, as, excepting the cities of Richmond and Norfolk, they have no one to leave their patients with when they are away from home."

West Virginia Homœopathic Medical Society. Organized 1898. Not incorporated. The annual meeting is held, alternately, in different cities in the State, in the month of May of each year. The 1902 meeting was held in Wheeling, W. Va. President, George S. Wells, M. D., Sistersville, W. Va. Secretary, Arthur A. Roberts, M. D., Wellsburg, W. Va. Number of members, 16; admitted last year, 5. Annual dues, $3.00. "West Virginia has only twenty-three homœopathic physicians that I have been able to find in any published directory of the physicians of the State. There are many good towns where Homœopathy would make a very good showing, provided some good, energetic M. D.'s would come to them and establish themselves. These locations are in towns with populations varying from two thousand to ten thousand. There was a joint meeting of the Ohio Valley Homœopathic Medical Society and our society held at Wheeling, W. Va., on May 20, 1902, and another joint meeting will be held in Marietta, Ohio, on October 14, 1902."

Washington State Homœopathic Medical Society. Organized 1889. Not incorporated. The annual meeting is held, alternately, in the cities of Seattle, Tacoma and Spokane, on the second Thursday of June in each year.

Homœopathic Medical Society of the State of Wisconsin. Organized 1864. Incorporated 1868. The annual meeting is held in Milwaukee and some other large city in Wisconsin, alternately, on the third Wednesday in May of each year. President, Filip A. Forsbeck, M. D., 121 Wisconsin street, Milwaukee, Wis. Secretary, Walter W. Irving, M. D., 121 Wisconsin street, Milwaukee, Wis. Number of members, 104; admitted last year, 24; died last year, 1. Annual dues, $2.00. Publishes its "Transactions" in a Homœopathic journal. Delegates, Eugene W. Beebe, M. D.; Milton A. Barndt, M. D.

LOCAL SOCIETIES.

Arkansas.

Little Rock Homœopathic Medical Society. Organized 1900. Not incorporated. The annual meeting is held in Little Rock, Ark. Monthly meetings are held in the same place.

California.

Alameda County Homœopathic Medical Society. Organized 1877. Incorporated 1877. The annual meeting is held in Oakland, Cal., on the second Tuesday in October of each year. Monthly meetings are held in the same place on the second Tuesday of each month.

San Diego Homœopathic Medical Society. Organized 1889. Not incorporated. The annual meeting is held in San Diego, Cal., on the third Wednesday of December of each year. Monthly meetings are held in the same place on the third Wednesday of each month. President, S. Eveline Bailey, M. D., Eighth street, San Diego, Cal. Secretary, Thomas Docking, M. D., 112 Boston avenue, San Diego, Cal. Number of members, 15. Annual dues, $2.00. Delegate, Thomas Docking, M. D.

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San Francisco Homœopathic Medical Society. Organized 1863. Not incorporated. The annual meeting is held in San Francisco on the second Friday in January of each year. Monthly meetings are held in the same place on the second Friday of each month. President, Guy E. Manning, M. D., Spring Valley Water building, San Francisco, Cal. Secretary, Laura B. Hurd, M. D., 706 Sutter street, San Francisco, Cal. Number of members, 50; admitted last year, 2; died last year, 2. Annual dues, $1.00. Has published the different papers read at the meetings in the Pacific Coast Journal of Homœopathy.

Southern California Homœopathic Medical Society. Organized 1895. Incorporated 1892. The annual meeting is usually held in Los Angeles, Cal., on the second Wednesday in October of each year. President, S. H. Boynton, M. D., 1019 South Hill street, Los Angeles, Cal. Secretary, Frank S. Barnard, M. D., 444 Douglass building, Los Angeles, Cal. Number of members, 78; admitted last year, 9; died last year, 2. Annual dues, $1.00. The papers read at the meetings were printed in the Pacific Coast Journal of Homœopathy.

Homœopathic Hospital Association of Southern California. Organized 1895. Incorporated 1895. The annual meeting is held in Los Angeles, Cal., on the first Tuesday in March of each year. Monthly meetings are held in the same place on the first Tuesday in each month. President, James Foord, M. D., 218 North Main street, Los Angeles, Cal. Secretary, Frank S. Barnard, M. D., 444 Douglass building, Los Angeles, Cal. Number of members, 17; admitted last year, 2; died last year, 1. Annual dues, $5.00.

Connecticut.

Bridgeport Homœopathic Medical Society. Organized 1895. Not incorporated. The annual meeting is held in Bridgeport, Conn., on the third Tuesday in September of each year. Monthly meetings are held in the same place on the third Tuesday of each month. President, Edward S. Smith, M. D., 433 West avenue, Bridgeport, Conn. Secretary, David W. Ingalls, M. D., 461 State street, Bridgeport, Conn. Number of members, 8. Annual dues, $1.00.

District of Columbia.

Washington Homœpathic Medical Society. Organized 1870. Incorporated 1870. The annual meeting is held in Washington, D. C., on the first Tuesday in December of each year. Monthly meetings are held in the same place on the first Tuesday in each month. President, George W. N. Custis, M. D., 110 East Capitol street, Washington, D. C. Secretary, Alfred H. Taylor, M. D., 485 H street, S. W., Washington, D. C. Number of members, 53; admitted last year, 2. Annual dues, $2.00. Delegates, J. B. Gregg Custis, M. D., William R. King, M. D.

Illinois.

Central Illinois Homœopathic Medical Society. Organized 1897. Not incorporated. The annual meeting is held in Bloomington, Ill., on the third Tuesday in May of each year. The semi-annual meeting is held in different places, alternately, on the third Tuesday in October of each year. President, Samuel Bishop, M. D., Bloomington, Ill. Secretary, William E. Neiberger, M. D., Bloomington, Ill. Number of members, 63; admitted last year, 7. Annual dues, $1.00. Papers which have been read have been published in the North American Journal of Homœopathy, The Medical Visitor, and the Medical Counsellor.

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Clinical Society of Hahnemann Hospital of Chicago. Organized 1877. Not incorporated. The annual meeting is held at the Hahnemann College, Chicago, Ill., on the last Monday night in April of each year. Monthly meetings are held in the same place on the last Monday evening in each month. President, O. L. Smith, M. D., 31 East Washington street, Chicago, Ill. Secretary, Walter B. McGibben, M. D., 153 East Fifty-third street, Chicago, Ill. Number of members, 109; admitted last year, 47; Annual dues, $1.00, O. L. Smith, M. D., Walter P. McGibben, M. D. "The Clinique" is the official organ of the Society. "There have been twelve meetings held during the past year. During this time twenty-four papers have been presented before the Society, and seventy-two discussions have been made on these papers; both papers and discussions have been printed in the "Clinique." In addition, several papers written for the Society, which for various reasons were not read before it, have been printed in "The Clinique," and extracts of a majority of the papers and discussions have been published in "The Medical Century," signed W. P. McGibben, Secretary.

Chicago Materia Medica Society. Organized 1899. Not incorporated. The annual meeting is held in Chicago, Ill., in September of each year. Semi-annual meeting is held in the same place in the month of March of each year. President, Thomas C. Duncan, M. D., 100 State street, Chicago, Ill. Secretary, Peter S. Replogle, M. D., 92 State street, Chicago, Ill. Number of members 40. Delegate, Thomas O. Duncan, M. D.

Homœopathic Medical Society of Chicago. Organized 1894. Not incorporated. The annual meeting is held in Chicago, Ill., on the third Thursday in April of each year. Monthly meetings are held in the same place on the third Thursday in each month, from September to April, inclusive. President, Mary Elizabeth Hawks, M. D., 20 Bellevue Place, Chicago, Ill. Secretary, W. Henry Wilson, M. D., 3924 Rhodes avenue, Chicago, Ill. Number of members, 105; admitted last year, 2; died last year, 1. Annual dues, $2.00. The discussions and many of the papers read at the meetings have been published in the Medical visitor.

"The Old Guard." Organized 1899. Not incorporated. The annual meeting is held in Chicago, Ill., on the first Tuesday in June of each year. President, William W. Estabrooke, M. D., 377½ La Salle avenue, Chicago, Ill. Secretary, Thomas C. Duncan, M. D., 100 State street, Chicago, Ill. Number of members, 51; admitted last year, 7; died last last year, 1, Dr. Adam Miller, aged eighty-two years. Annual dues, fifty cents. Delegate, Lemuel C. Grosvenor, M. D. This Society is composed of Homœopathic physicians who have been thirty years' graduates, residing in Chicago and vicinity.

Desplaines Valley Medical Society. Organized 1898. Not incorporated. The annual meeting is held in Joliet, Ill. President, A. R. Fouser, M. D., Canton, Ill. Secretary, H. M. Beckwith, M. D., 304 Barber Building, Joliet, Ill. Number of members, 19.

Englewood Homœopathic Medical Society. Organized 1897. Not incorporated. The annual meeting is held in Englewood, Ill., on the second Tuesday in May of each year. Semi-monthly meetings are held in the same place on the second and fourth Tuesdays in each month. President, James Nash Hingston, M. D., 1106-92 State street, Chicago, Ill. Secretary, Della M. MacMullen, M. D., 6502 Wentworth avenue, Chicago, Ill. Number of members, 36; admitted last year, 13. Annual dues, $1.00. Delegate, John B. S. King, M. D.

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Northwestern Illinois Homœopathic Medical Society. Organized 1895. Incorporated 1895. No report could be obtained from this society this year.

Rock River Institute of Homœopathy. Organized 1881. Not incorporated. The annual meeting is held in Dixon, Ill., on the first Wednesday in October of each year. Quarterly meetings are held in different places in the State, alternately, on the first Wednesday in the months of January, April and July of each year. President, C. Gruber, M. D., Clinton, Iowa. Secretary, Arthur W. Blunt, M. D., Clinton, Iowa. Number of members, 29; admitted last year 2. Annual dues, fifty cents.

Indiana.

Evansville Homœopathic Medical Society. Organized 1894. Not incorporated. The annual meeting is held in Evansville, Ind., on the first Tuesday in December of each year. Monthly meetings are held in the same place on the first Tuesday in each month. President, D. B. Cain, M. D., Evansville, Ind. Secretary, Theodore B. Taylor, M. D., Evansville, Ind. Number of members, 9; died last year, 1. Annual dues, $1.00.

Grant County Homœopathic Institute. Organized 1899. It has been impossible to obtain any report from this society this year.

Indianapolis Homœopathic Medical Society. Organized 1894. Not incorporated. Semi-monthly meetings are held in parlors of Hotel English, Indianapolis, Ind. President, A. A. Ogle, M. D., 2314 East Washington street, Indianapolis, Ind. Secretary, William E. George, M. D., Marion Building Indianapolis, Ind. Number of members, 20; admitted last year, 2; died last year, 1. Annual dues, $2.00. Delegate, Orange S. Runnels, M. D.

Northern Indiana and Southern Michigan Homœopathic Medical Association. Organized 1891. Not incorporated. The annual meeting is held in Elkhart, Ind., on the fourth Tuesday in April of each year. The semi-annual meeting is held in the same place on the fourth Tuesday in September of each year. President, Julius A. Godfrey, M. D., South Bend, Ind. Secretary, Henry A. Mumaw, M. D., Elkhart, Ind. Number of members, 101; admitted last year, 12; died last year, 1. Annual dues, $1.00.

Iowa.

Central Homœopathic Association of Iowa. Organized 1878. Incorporated 1879. The annual meeting is held in Cedar Rapids, Iowa, on the second Wednesday in July of each year. The semi-annual meeting is held in different places in the State. alternately, on the first Wednesday after Christmas of each year. President, Ermina Richardson, M. D., Cedar Rapids, Iowa. Secretary, D. E. Tiffany, M. D., Cedar Rapids, Iowa. Number of members. 45; admitted last year, 4.

Des Moines Homœopathic Medical Society. Organized 1883. Not incorporated. The annual meeting is held in Waterloo, Iowa, on the second Tuesday in January of each year. Monthly meetings are held in Des Moines, Iowa, on the second Tuesday in each month. President. C. J. Lorzeaux, M. D., East Fourteenth street and Grand avenue, Des Moines, Iowa. Secretary, Erwin Schenck, M. D., 2001 Forest avenue, Des Moines, Iowa. Number of members, 17; admitted last year, 1; died last year, 1. Annual dues, $1.00. Delegates, Erwin Schenck, M. D., Lucy M. Busenbach-Herbach, M. D.

Johnson County Homœopathic Medical Society. Organized 1892. Not incorporated. The annual meeting is held at Iowa City, Iowa, on the first

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Wednesday in March of each year. Weekly meetings are held every Wednesday during the "School Year" in the lecture room of the hospital. President, James G. Gilchrist, M. D., 215 College avenue, Iowa City, Iowa. Secretary, Clara M. Hazard, M. D., 22 North Clinton street, Iowa City, Iowa. "Our society has not held any meetings for two years, chiefly from lack of time and interest among its members. If more of our members would attend the meetings of the A. I. H., we might be able to revive the interest in our own society.

Northwestern Iowa Homœopathic Medical Society. Organized 1896. Not incorporated. It has been impossible to obtai nany report from this society this year.

Sioux City Homœopathic Medical Association. Organized 1889. Not incorporated. The annual meeting is held in Sioux City, Iowa, on the first Tuesday in March of each year. Monthly meetings are held in the same place on the first Tuesday in each month. President, A. L. Day, M. D., Security Bank Building, Sioux City, Iowa. Secretary, John L. Hanchette, M. D., Toy Building, Sioux City, Iowa. Number of members, 15; died last year, 1. Annual dues, $1.00. "During last year we held eleven meetings, at each of which one or two papers were read and discussed."

Kentucky.

Falls Cities Homœopathic Medical Society. Organized 1897. Not incorporated. The annual meeting is held in the Southwestern Homœopathic Medical College Building, Louisville, Ky., on the second Friday of October of each year. Monthly meetings are held in the same place on the second Friday in each month. President, W. J. Pinkert, M. D., 1147 East Broadway, Louisville, Ky. Secretary, S. E. Stanley, M. D., Seventh and Jefferson streets, Louisville, Ky. Number of members, 25; admitted last year, 3. Delegate, George S. Coon, M. D.

Massachusetts.

Boston Homœopathic Medical Society. Organized 1873. Incorporated 1873. The annual meeting is held in Boston, Mass., on the first Thursday in January of each year. Monthly meetings are held in the same place on the first Thursday of each month. President, Frank E. Allard, M. D., 373 Commonwealth avenue, Boston, Mass. Secretary, Henry O. Spalding, M. D., 50 Seaverns avenue, Jamaica Plain, Boston, Mass. Number of members, 238; admitted last year, 9; died last year, 2. Annual dues, $2.00. Publishes a "Year Book," containing officers' reports, business transactions and directory of members.

Essex County Homœopathic Medical Society. Organized 1871. Not incorporated. The annual meeting is held in Salem, Mass., on the last Wednesday in October of each year. Monthly meetings are held in Salem and Lynn, alternately, on the last Wednesday of each month.

Massachusetts Surgical and Gynæcological Society. Organized 1877. Not incorporated. The annual meeting is held in Boston, Mass., on the second Wednesday in December of each year. The semi-annual meeting is held in the same place on the second Wednesday in June of each year. President, G. Forrest Martin, M. D., Lynn, Mass. Secretary, T. Morris Strong, M. D., 176 Huntington avenue, Boston, Mass. Number of members, 204; admitted last year, 14; died last year, 3. Annual dues, $2.00. Publishes the papers read

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at the meetings, and the discussions, in the journals. Delegate, G. Forrest Martin, M. D.

Homœopathic Medical Society of Western Massachusetts. Organized 1877. Not incorporated. The annual meeting is held in Springfield, Mass., on the third Wednesday in March of each year. Quarterly meetings are held in the same place on the third Wednesdays in June, September and December of each year. President, Samuel Fletcher, M. D. Secretary, Alice E. Rowe, M. D., 9 Maple street, Springfield, Mass. Number of members, 61. Annual dues. $2.00. Delegate, Alvin M. Cushing, M. D.

Worcester County Homœopathic Medical Society. Organized 1866. Not incorporated. The annual meeting is held in Worcester, Mass., on the second Wednesday in November of each year. Quarterly meetings are held in different places, alternately, on the second Wednesdays in February, May and August of each year. President, A. J. Atwood, M. D., Townsend, Mass. Secretary, Edwin Roy Lieb, M. D., 49 Pleasant street, Worcester, Mass. Number of members, 78; admitted last year, 3; died last year, 2. Annual dues, $1.00. Delegate, John P. Rand, M. D.

Michigan.

Homœopathic Medical Society of Southwestern Michigan. Organized 1866. Not incorporated. The annual meeting is held in Kalamazoo, Mich., on the first Tuesday in February of each year. Bi-monthly meetings are held in different places, alternately, on the first Tuesdays in April, June, August, October and December of each year. President, Albert B. Cornell, M. D., Kalamazoo, Mich. Secretary, Nancy B. Sherman, M. D., Janesville, Wis. Number of members, 20. Annual dues, $1.00. "There have been no meetings held for several years, and the Society is not in very active existence; still we are anxiously hoping and looking for better times."

Detroit Homœopathic Practitioners' Society. Organized 1894. Not incorporated. The annual meeting is held in The Grace Hospital, Detroit, Mich., on the first Thursday in June of each year. Monthly meetings are held in the same place on the first Thursday in each month. President, E. Louise Orleman, M. D., 30 Bagg street, Detroit, Mich. Secretary, Edward J. Kendall, M. D., 78 West Elizabeth street, Detroit, Mich. Number of members, 26; admitted last year, 2. Annual dues, $1.00. Delegates, G. W. Augustin, M. D.

Minnesota.

St. Paul's Society of Homœopathic Medicine and Surgery. Organized 1894. Not incorporated. The annual meeting is held in St. Paul, Minn., on the first Monday in January of each year. Monthly meetings are held in the same place on the first Monday evening in each month. President, Oscar H. Hall, M. D., Germania Bank Building, St. Paul, Minn. Secretary, Reginald B. Leach, M. D., Germania Bank Building, St. Paul, Minn. Number of members, 28; admitted last year, 4. Annual dues, $1.00. Delegates, B. H. Ogden, M. D., Warren S. Briggs, M. D.

Missouri.

St. Louis Homœopathic Medical Society. Organized 1886. Not incorporated. The annual meeting is held at the Wset End Hotel, St. Louis, Mo., on the second Saturday in October of each year. Semi-monthly meetings are held in the same place on the second and fourth Saturdays in each month,

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from October to June, inclusive. President, H. W. Hartwell, M. D., 3894 Washington avenue, St. Louis, Mo. Secretary, F. W. Lester, M. D., 2016 Victor street, St. Louis, Mo. Number of members, 75; admitted last year, 4. Annual dues, $2.00. Delegate, Willis B. Morgan, M. D.

Nebraska.

Omaha Homœopathic Medical Society. Organized 1879. Incorporated 1879. The annual meeting is held in Omaha, Neb. Monthly meetings are held in the same place. President, Endell N. Leake, M. D., Fremont, Neb. Secretary, H. R. Miner, M. D., Falls City, Neb. Number of members, 150; admitted last year, 10. Annual dues, $1.00. Delegates, William H. Hanchett, M. D., Endell N. Leake, M. D.

New Jersey.

West Jersey Homœopathic Medical Society. Organized 1869. Not incorporated. The annual meeting is held in the Homœopathic Hospital, Camden, N. J., on the third Wednesday in May of each year. Quarterly meetings are held in the same place on the third Wednesdays in August, November and February of each year. President, Henry Knox Stewart, M. D., 1627 Fairmount avenue, Philadelphia, Pa. Secretary, Wallace McGeorge, M. D., 521 Broadway, Camden, N. J. Number of members, 53; admitted last year, 3; died last year, 2. Annual dues, $1.00. Some of the papers read at the meetings have been published in the Hahnemannian Monthly. Delegates, Erving M. Howard, M. D., Jacob G. Streets, M. D. "The last annual meeting was the largest in attendance we have ever had, 50 per cent of our members being present. In the November meeting, when smallpox and vaccination were discussed, we had twenty-three members present, and twenty-five visiting physicians from Pennsylvania and New Jersey honored us with their presence. The papers were of note, and the discussions were warm, and the entire meeting was perfectly enjoyable."

New York.

Albany County Homœopathic Medical Society. Organized 1861. Incorporated 1861. The annual meeting is hel din Albany, N. Y., on the second Thursday in January of each year. Quarterly meetings are held in the same place on the second Thursdays in April, July and October of each year. President, J. Ivemy Dowling, M. D., 223 State street, Albany, N. Y. Secretary, Frederick J. Cox, M. D., 109 State street, Albany, N. Y. Number of members, 51; admitted last year, 7. Annual dues, $2.00. Delegate, J. Ivemy Dowling, M. D.

Brooklyn Hahnemann Union. Organized 1896. Not incorporated. The annual meeting is held in Brooklyn, N. Y., on the last Saturday in January of each year. Monthly meetings are held in the same place on the last Saturday of each month. The President is chosen at each meeting. Secretary, Mrs. Evangeline L. Close, 209 Hancock street, Brooklyn, N. Y. Number of members, 14; admitted last year, 1. Some of the papers which have been read at the metings have been published in the Homœopathic journals. "An original paper on a chosen topic is presented and read at each meeting, followed by a discussion upon it."

Broome County Homœopathic Medical Society. Organized 1863. Incor-

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porated 1882. The annual meeting is held in Binghamton, N. Y., on the third Wednesday in June of each year. The semi-annual meeting is usually held in the same place on the third Wednesday in December of each year.

Chenango County Homœopathic Medical Society. Organized 1871. Incorporated 1872. The annual meeting is held in Norwich, N. Y., on the third Tuesday in January of each year. The semi-annual meeting is held at different places in the County, alternately, on the third Tuesday in June of each year. President, Robert E. Miller, M. D., Oxford, N. Y. Secretary, F. Eugene Roper, M. D., Norwich, N. Y. Number of members, 5. Annual dues, $1.00.

Cortland County Homœopathic Medical Society. Organized 1879. Not incorporated. The annual meeting is held in Cortland, N. Y., in the month of May of each year. Quarterly meetings are held alternately in Homer and Cortland, in the months of February, August and November of each year. President, Leonard W. Potter, M. D., Homer, N. Y. Secretary, Ellis M. Santee, M. D., Cortland, N. Y. Number of members, 9; admitted last year, 1. Annual dues, $1.00.

Central New York Homœopathic Medical Society. Organized 1865. Incorporated 1866. The annual meeting is held in Syracuse, N. Y., on the third Thursday in September of each year. Quarterly meetings are held in Syracuse and Rochester, alternately, on the third Thursdays in December, March and June of each year. President, Edward P. Hussey, M. D., 473 Porter avenue, Buffalo, N. Y. Secretary, S. L. Guild-Leggett, M. D., 207 Furman street, N. Y. Number of members, 40; admitted last year, 4; died last year, 2. Annual dues, $1.00. Have published the Transactions in the Medical Advance.

Duchess County Homœopathic Medical Society. Organized 1860. Incorporated 1868. The annual meeting is held in Poughkeepsie, N. Y., on the third Tuesday in October of each year. The semi-annual meeting is held in different places in the county, alternately, on the third Tuesday in May of each year. President, John H. Otis, M. D., 319 Mill street, Poughkeepsie, N. Y. Secretary, A. L. Peckham, M. D., 31 Cannon street, Poughkeepsie, N. Y. Number of members, 12. Annual dues, $1.00. Delegate, A. L. Peckham, M. D.

Homœopathic Medical Society of the County of Kings. Organized 1857. Incorporated 1857. The annual meeting is held in Brooklyn, N. Y., on the second Tuesday in January of each year. Monthly meetings are held in the same place on the second Tuesday in each month. President, W. S. Rink, M. D., Brooklyn, N. Y. Secretary, Ralph O. Lloyd, M. D., 450 Ninth street, Brooklyn, N. Y. Number of members, 150; admitted last year, 6; died last year, 6. Annual dues, $2.00. Delegate, E. Rodney Fiske, M. D.

Homœopathic Medical Society of the County of New York. Organized 1857. Incorporated 1857. The annual meeting is held in New York City on the second Thursday in December of each year. Monthly meetings are held in the same place on the second Thursday of each month. President, William H. Van den Burg, M. D., 32 West Forty-ninth street, New York City. Secretary, J. Perry Seward, M. D., 200 West Seventieth street, New York City. Number of members, 345; admitted last year, 106; died last year, 3. Annual dues, $3.00. Publishes its Transactions in N. A. Journal of Homœopathy.

Jamestown Homœopathic Medical Society. Organized 1894. Not incor-

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porated. The annual meeting is held in Jamestown, N. Y., on the second Tuesday in January of each year. Monthly meetings are held in the same place on the second Tuesday in each month. President, Henry Neville, M. D., Jamestown, N. Y. Secretary, Alvin B. Rice, M. D. Number of members, 8.

Jefferson County Homœopathic Medical Society. Organized 1888. Incorporated 1888. The annual meeting is held in Watertown, N. Y., on the third Wednesday in October of each year. Quarterly meetings are held in the same place on the third Wednesdays of February and June of each year.

Homœopathic Medical Society of Madison County. Organized 1865. Not incorporated. The annual meeting is held in Oneida on the fourth Tuesday in June of each year. The semi-annual meeting is held in different places in the County, alternately, on the fourth Tuesday in December of each year. President, Barton R. Gifford, M. D., Madison, N. Y. Secretary, Jason T. Wallace, M. D., Oneida, N. Y. Number of members, 8.

Medico-Chirurgical Society of Central New York. Organized 1896. Not incorporated. The annual meeting is held in Syracuse, N. Y., on the first Thursday in June of each year. The semi-annual meeting is held in different places, alternately, on the first Thursday in December of each year. President, Jason T. Wallace, M. D., Oneida, N. Y. Secretary, Ellis M. Santee, M. D., Cortland, N. Y. Number of members, 72; admitted last year, 3. Annual dues, $1.00. Have published a number of the papers which have been read at the meetings, in the Syracuse Clinic. "This society is a live one."

Monroe County Homœopathic Medical Society. Organized 1866. Incorporated 1872. The annual meeting is held in Rochester, N. Y., on the third Tuesday in January of each year. Quarterly meetings are held in the same place on the third Tuesdays in April, July and October of each year. President, W. H. Doane, Pittsford, N. Y. Secretary, Llewellyn J. Sanders, M. D., 421 Monroe street, Rochester, N. Y. Number of members, 47; admitted last year, 4. Annual dues, $2.00.

Montgomery County Homœopathic Medical Society. Organized 1881. Incorporated 1899. The annual meeting is held in Fonda, N. Y., on the third Wednesday in January of each year. Quarterly meetings are held in the same place on the third Wednesdays in April, July and October of each year. President, H. M. Hicks, M. D., Amsterdam, N. Y. Secretary, Emily L. Hill, M. D., Gloversville, N. Y. Number of members, 19; admitted last year, 6. Annual dues, $1.00. Delegate, Walter Spohr, M. D. "The society has taken on a new life; the meetings were never so well attended, and they have never been as intersting as during the last year."

Academy of Pathological Science. Organized 1883. Not incorporated. The annual meeting is held in New York City on the fourth Friday in November of each year. Monthly meetings are held in the same place on the fourth Friday in each month, from October to May, inclusive, of each year. President, George Frederick Laidlaw, M. D., 58 West Fifty-third street, New York City. Secretary, Walter Sands Mills, M. D., 152 West One Hundred and Nineteenth street, New York City. Number of members, 122. Annual dues, $1.00. "The society is in a very flourishing condition, and is doing most excellent work."

New York Homœopathic Materia Medica Society. Organized 1891. Not

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incorporated. The annual meeting is held in New York City on the third Wednesday in December of each year. Monthly meetings are held in the same place on the third Wednesday in each month. President, Walter Sands Mills, M. D., 152 West One Hundred and Nineteenth street, New York City. Secretary, Charles Ver Nooy, M. D., 146 West Sixty-fourth street, New York City. Number of members, 78. Annual dues, $1.00.

New York Pædological Society, Homœopathic. Organized 1891. Not incorporated. The annual meeting is held in New York City on the third Wednesday in October of each year. Monthly meetings are held in the same place on the third Wednesday in each month, from October to May, inclusive, of each year. President, Frederick M. Hamlin, M. D., 130 West Forty-eighth street, New York City. Secretary, J. Edward Ambler, M. D., 134 East Nineteenth street, New York City. Number of members, 77; admitted last year, 5; Annual dues, $1.00. Delegate, Frederick M. Hamlin, M. D.

Onondaga County Homœopathic Medical Society. Organized 1863. Incorporated 1864. The annual meeting is held in Syracuse, N. Y., in the month of May of each year. Monthly meetings are held in the same place. President, F. Hooker, M. D., Syracuse, N. Y. Secretary, Mumford Keese, M. D., Syracuse, N. Y. Number of members, 30; admitted last year, 2. Annual dues, $1.00.

Ontario County Homœopathic Medical Society. Organized 1861. Not incorporated. The annual meeting is held in Canandaigua, N. Y., on the first Wednesday in June of each year. The semi-annual meeting is held, alternately, in Clifton Springs, N. Y., and Geneva, N. Y., on the first Wednesday in October of each year. President, James C. Knapp, M. D., Geneva, N. Y. Secretary, Charles T. Mitchell, M. D., Canandaigua, N. Y. Number of members, 9. Delegate, N. B. Covert, M. D. "No meeting has been held for the past three years, the old officers holding over."

Oswego County Homœopathic Medical Society. Organized 1861. Not incorporated. The annual meeting is held in Oswego, N. Y., on the second Tuesday in June of each year. The semi-annual meeting is held in different places in the County, alternately, on the second Tuesday in December of each year. President, A. C. Calisch, M. D., Oswego, N. Y. Secretary, Llewellyn B. Richards, M. D., Oswego, N. Y. Number of members, 9; admitted last year, 1.

Rochester Hahnemannian Society. Organized 1886. Not incorporated. The annual meeting is held in Hahnemann Hospital, Rochester, N. Y., on the third Tuesday in December of each year. Monthly meetings are held in the same place on the third Tuesday in each month. President, M. E. Graham, M. D., 1100 South avenue, Rochester, N. Y. Secretary, John K. Tretton, M. D., 601 Lake avenue, Rochester, N. Y. Number of members, 12; admitted last year, 2. Annual dues, $2.00.

Southern Tier Homœopathic Medical Association. Organized 1874. Incorporated 1878. The annual meeting is held in Corning, N. Y., on the third Tuesday in January of each year. Quarterly meetings are held in different places, alternately, on the third Tuesdays in April, July and October of each year. President, Mark S. Purdy, M. D., Corning, N. Y. Secretary, Albert H. Rodgers, M. D., Corning, N. Y. Number of members, 20; admitted last year, 1; died last year, 1. Annual dues, $1.00.

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Westchester Homœopathic Medical Society. Organized 1865. Incorporated 1865. The annual meeting is held in Yonkers, N. Y., on the last Wednesday in October of each year. The semi-annual meeting is held in different places in the County, alternately, on the last Wednesday in May of each year. President, Perley H. Mason, M. D., Peekskill, N. Y. Secretary, Horace G. Keith, M. D., 317 South Broadway, Yonkers, N. Y. Number of members, 33; admitted last year, 3. Annual dues, $1.00.

Western New York Homœopathic Medical Society. Organized 1885. Not incorporated. The annual meeting is held in Buffalo and Rochester, alternately, on the second Friday in April of each year. Quarterly meetings are held in different places in Western New York, alternately, on the second Fridays in July, October and January of each year. President, Emily F. Swett, M. D., Medina, N. Y. Secretary, George R. Critchlow, M. D., 505 Norwood avenue, Buffalo, N. Y. Number of members, 154; admitted last year, 3; died last year, 3. Annual dues, $1.00. Delegate, Emily F. Swett, M. D.

Ohio.

Cincinnati Homœopathic Lyceum. Organized 1889. Not incorporated. The annual meeting is held in Pulte Medical College Building, Cincinnati, Ohio, on the second Wednesday in April of each year. Monthly meetings are held in the same place on the second Wednesday in each month, from October to April, inclusive, of each year. President, Charles D. Crank, M. D., 2405 Auburn avenue, Cincinnati, Ohio. Secretary, Ida E. McCormick, M. D., 3110 Woodburn avenue, Cincinnati, Ohio. Number of members, 66; admitted last year, 4. Annual dues, $1.00.

Cleveland Homœopathic Medical Society. Organized 1890. Incorporated 1890. The annual meeting is held in Cleveland, Ohio, on the third Wednesday in February of each year. Monthly meetings are held in the same place on the third Wednesday in each month. President, William T. Miller, M. D., King-Moore Building, Cleveland, Ohio. Secretary, Pauline H. Barton, M. D., 720 Rose Building, Cleveland, Ohio. Number of members, 110; admitted last year, 16. Annual dues, $1.00. Delegates, William T. Miller, M. D., G. D. Cameron, M. D., Pauline H. Barton, M. D. The abstracts of the meetings have been published.

Columbus Homœopathic Medical Society. Organized 1897. Not incorporated. The annual meeting is held in Columbus, Ohio, on the first Monday in October of each year. Monthly meetings are held in the same place on the first Monday in each month. President, R. O. Keiser, M. D., 54 North Washington avenue, Columbus, Ohio. Secretary, A. B. Castle, M. D., 1006 North High street, Columbus, Ohio. Number of members, 31. Annual dues, $1.00. "This society is, perhaps, not dead, but is in a comatose condition. No meetings have been held during the past year. Several efforts have been made to get a meeting, but a constitutional quorum could not be secured. It is to be hoped that something may be accomplished in the way of getting a meeting some time in the near future."

Dayton Homœopathic Medical Society. Organized 1894. Not incorporated. The annual meeting is held in Dayton, Ohio, on the first Monday in September of each year. Semi-monthly meetings are held in the same place on the first and third Mondays of every month. President, William

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H. Webster, M. D., 238 North Ludlow street, Dayton, Ohio. Secretary, T. L. Laughlin, M. D., 527 River street, Dayton, Ohio. Number of members, 26. Annual dues, $3.00.

Homœopathic Medical Society of Eastern Ohio. Organized 1872. Not incorporated. The annual meeting is held in Akron, Ohio, on the third Wednesday in April of each year. The semi-annual meeting is held in different cities in Eastern Ohio, alternately, on the third Wednesday in October of each year. President, S. B. Croft, M. D., Medina, Ohio. Secretary, Edwin J. Cauffield, M. D., Akron, Ohio. Number of members, 155; number admitted last year, 35; died last year, 2. Delegate, Rolla B. Carter, M. D. Nearly all the papers presented at the meetings were published in some medical journal. At the last meeting of the Society, the Cleveland Reporter was made the official organ of the society."

Miami Valley Homœopathic Medical Society. Organized 1860. Incorporated 1870. The annual meeting is held in Dayton, Ohio, on the last Thursday in October of each year. The semi-annual meeting is held in different places, alternately, on the last Thursday in April of each year. President, T. A. McCann, M. D., 115 North Perry street, Dayton, Ohio. Secretary, W. Webster Ensey, M. D., 405 South Brown street, Dayton, Ohio. Number of members, 137; admitted last year, 18. Delegates, Jared D. Buck, M. D., C. R. Coffin, M. D. "The papers read at the meetings have been published in the medical journals. The last meeting, held in Cincinnati, was one of the largest and most enthusiastic in the history of the society."

Northwestern Ohio Homœopathic Medical Society. Organized 1893. Incorporated 1893. The annual meeting is usually held in Toledo, Ohio, on the second Tuesday in December of each year. The semi-annual meeting, an informal one for the election of officers, is held in Toledo, Ohio, on the second Tuesday in June of each year. President, J. H. McVay, M. D., Toledo, Ohio. Secretary, William A. Humphrey, M. D. Toledo, Ohio. Number of members, 75; admitted last year, 5. Annual dues, $1.00. The papers which have been read and discussed at the meetings have been published in the medical journals.

Ohio Valley Homœopathic Medical Society. Organized in 1901. Not incorporated. Quarterly meetings are held, alternately, in different places. President, William B. McClure, M. D., Martin's Ferry, Ohio. Secretary, William N. Rogers, M. D., Bellaire, Ohio. Number of members, 12.

Summit County Clinical Society. Organized 1885. Not incorporated. The annual meeting is held in Akron, Ohio, on the first Tuesday in January of each year. Monthly meetings are held in the same place on the first Tuesday in every month. President, C. H. Whipple M. D., Barberton, Ohio. Secretary, Katherine Kurt, M. D., 113 South Broadway, Akron, Ohio. Number of members, 18; admitted last year, 3. Delegates, O. D. Childs, M. D., William Murdock, M. D. "At each of the annual meetings for the last two years there has been a banquet given, which has proved quite a success. At the last one the following programme was carried out:

1. Why I Am a Homœopath.....C. A. Dixon, M. D.
2. The State Law of Examination and Registration—Does It Profit the People?.....D. E. Cranz, M. D.
3. The Law of Similars Vindicated.....Katherine Kurt, M. D.

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4. The Silent Manifestation of the Homœopathic Remedy..K. W. Cory, M. D.
5. Methods of Taking a Case Now and When I Began to Practice; Do They Differ?.....H. W. Carter, M. D.
6. The Country Doctor.....F. D. Smith, M. D.
7. Clear Vision.—How Obtained from the Specialist...F. A. Clapsadel, M. D.
8. The Doctor's Day Book versus His Ledger.....E. J. Cauffield, M. D.
9. Value of Pathology to a Homœopathic Physician..W. A. Mansfield, M. D.
10. Has the Practice of Medicine a Scientific Basis?.....M. W. Kapp, M. D
11. A Theory of the Method of Action of Remedies....O. D. Childs, M. D.
12. Observations Abroad.....William Wilson, M. D.
13. Professional Ethics.....William Murdock, M. D.
14. Is the Doctor Successful, from a Business View?.....O. A. Lyon, M. D.
15. The Married versus the Single Doctor.....R. B. Carter, M. D.
16. Pointers.....J. W. Rockwell, M. D.
17. The Fraternal Side of Professional Life.....C. H. Whipple, M. D.

Pennsylvania.

Allegheny County Homœopathic Medical Society. Organized 1864. Not Incorporated. The annual meeting is held on the second Wednesday in December of each year in the Homœopathic Hospital, Pittsburg, Pa. Monthly meetings are held in the same place in the second Wednesday in every month. President, James H. McClelland, M. D., Fifth and Wilkins avenues, Pittsburg, Pa. Secretary, H. S. Nicholson, M. D., 621 Arch street, Allegheny, Pa. Number of members, 75. Annual dues, $2.00. Delegate, James H. McClelland, M. D.

Erie County Homœopathic Medical Society. Organized 1891. Not incorporated. The annual meeting is held in Erie, Pa., on the first Wednesday in January of each year. Quarterly meetings are held in the same place on the first Wednesdays in April, July and October of every year. President, Joseph Phillips, M. D., 15 East Eighth street, Erie, Pa. Secretary, Richard T. Marks, M. D., 252 West Eighteenth street, Erie, Pa. Number of members, 12. "No meetings have been held for the past two years, and it seems to be an impossibility to get the members together; several efforts have been made, but without any success. We shall try again, and hope for more success."

Goodno Homœopathic Medical Society. Organized 1881. Not incorporated. The annual meeting is held in Lancaster, Pa., on the second Friday of October of each year. Quarterly meetings are held in Harrisburg, York and Columbia, alternately, on the second Fridays of January, April and July of each year. President, Dr. Swartz, Harrisburg, Pa. Secretary, E. T. Prizer, M. D., Lancaster, Pa. Number of members, 30; number admitted last year, 4. Annual dues, $1.00.

Homœopathic Medical Society of Chester, Delaware and Montgomery Counties. Organized 1858. Not incorporated. The annual meeting is usually held in Philadelphia, Pa., on the scond Tuesday in October of each year. Bi-monthly meetings are held in different places, alternately, on the second Tuesdays in December, February, April, June and August of each year; the December and February meetings are usually held in Philadelphia, the April meeting in Chester, and the June and August meetings in other places. President, Samuel G. Godshall, M. D., Edge Hill, Pa. Secretary, Isaac

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Crowther, M. D., 700 Madison street, Chester, Pa. Number of members, 58; admitted last year, 3; died last year, 1. Annual dues, $1.00. The papers read at the meetings are published in the medical journals. Delegates, Charles H. Hubbard, M. D., Trimble Pratt, M. D. "The past year has been one of very good attendance, the average having been twenty-six; the papers have ben good; the discussions excellent; the interest large."

Homœopathic Medical Society of Delaware County. Organized 1898. Not incorporated. The annual meeting is held in different places, alternately, on the second Thursday in May of each year. Bi-monthly meetings are held in different places, alternately, on the second Thursdays in July, September, November, January and March of each year.

Homœopathic Medical Society of Germantown. Organized 1877. Not incorporated. The annual meeting is held in Germantown, Philadelphia, Pa., in January of each year. Monthly meetings are held in the same place.

Hahnemann Medical Association. Organized 1900. Not incorporated. The annual meeting is held during the opening week preceeding the opening of the annual session of Hahnemann Medical College of Philadelphia of each year. President, Henry S. Weaver, M. D. Secretary, Charles A. Ayres, M. D., 1648 South Broad street, Philadelphia, Pa.

Lackawanna County Homœopathic Medical Society. Organized 1900. Not incorporated. Monthly meetings are held in Scranton, Pa. President, Theodore Sureth, M. D., 1729 North Main street, Scranton, Pa. Secretary, J. Lyman Peck, M. D., 332 Washington avenue, Scranton, Pa. Number of members, 18; admitted last year, 3.

Lehigh Valley Homœopathic Medical Society. Organized 1881. Not incorporated. The annual meeting is held in Easton Pa., on the first Thursday in February of each year. Bi-monthly meetings are held in different places, alternately, on the first Thursdays in April, June, August, October and December of each year. President, Frank P. McKinstry, M. D., Washington, N. J. Secretary, H. H. Wilford, M. D., Bangor, Pa. Number of members, 26; admitted last year, 1. Annual dues, $1.00. Delegate, Frank P. McKinstry, M. D.

Luzerne County Homœopathic Medical Society. Organized 1899. Not incorporated. The annual meeting is held at Harvey's Lake, Luzerne County, Pa., on the fourth Friday in June of each year. Semi-monthly meetings are held in different places in the county, alternately, on the second and fourth Fridays in each month. President, E. H. Hill, M. D., Pittston, Pa. Secretary, J. Alfred Brooke, M. D., 1 Park avenue, Wilkesbarre, Pa. Number of members, 17; admitted last year, 3. Delegates, J. Arthur Bullard, M. D., Dr. Johnson.

Homœopathic Medical Society of Northern Pennsylvania. Organized 1880. Incorporated 1881. The annual meeting is held in Scranton and Wilkesbarre, alternately, on the third Thursday in June of each year. Bi-monthly meetings are held in these two cities, alternately, on the third Thursdays in August, October, December, February and April of each year. President, J. A. Brooke, Wilkesbarre, Pa. Secretary, Anna C. Clarke, M. D., Scranton, Pa. Number of members, 33; admitted last year, 3; died last year, 1. Annual dues, $2.00.

Homœopathic Medical Society of Philadelphia. Organized 1886. Not

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incorporated. The annual meeting is held in Philadelphia, Pa., on the second Thursday in June of each year. Monthly meetings are held in the same place on the second Thursday in each month. President, James Harwood, Closson, M. D., 53 North Chelten avenue, Germantown, Pa. Secretary, Herbert P. Liepold, M. D., 310 North Chelten avenue, Germantown, Philadelphia, Pa. Number of members, 324; admitted last year, 10; died last year, 2. Annual dues, $1.00. Publishes its "Transactions" in the Hahnemannian Monthly.

Homœopathic Medical Society of the Twenty-third Ward of Philadelphia. Organized 1881. Not incorporated. The annual meeting is held in Philadelphia, Pa., on the third Wednesday in October of each year. Monthly meetings are held in the same place on the third Wednesday in each month. President, R. S. Sommers, M. D., 2610 North Twelfth street, Philadelphia, Pa. Secretary, John D. Boileau, M. D., 804 Lehigh avenue, Philadelphia, Pa. Number of members, 30; admitted last year, 5. Annual dues, $1.00. Delegates, Richard C. Allen, M. D., John D. Boileau, M. D.

Philadelphia Medical and Surgical Society. Organized 1900. Not incorporated. The annual meeting is held in Philadelphia, Pa., on the third Wednesday in January of each year. Monthly meetings are held in the same place on the third Wednesday in each month. President, John J. Tuller, M. D., 1931 Chestnut street, Philadelphia, Pa. Secretary, William C. Hunsicker, M. D., 2111 North Twenty-ninth street, Philadelphia, Pa. Number of members, 22; admitted last year, 4. Delegate, Leon T. Ashcraft, M. D.

Pharmacological Society of Hahnemann College of Philadelphia. Organized 1885. Not incorporated. The annual meeting is held in Pilhadelphia, Pa., on the fourth Tuesday in October of each year. Monthly meetings are held in the same place on the fourth Tuesday in each month. President, Charles Mohr, M. D., Lawnton avenue, Oak Lane, Philadelphia, Pa. Secretary, Charles A. Ayres, M. D., 1643 South Broad street, Philadelphia, Pa. Number of members, 30. Delegate, Charles Mohr, M. D.

Woman's Homœopathic Medical Society of Pittsburg. Organized 1899. Not incorporated. President, Millie J. Chapman, M. D., 5525 Center avenue, Pittsburg, Pa. Secretary, Ella D. Goff, M. D. 10 North Diamond street, Allegheny, Pa. Number of members, 7; admitted last year, 2. Annual dues, $2.00. "One paper was presented at the State Society meeting in Pittsburg last September, and was printed in its Transactions."

Homœopathic Practitioners' Association of Reading. Organized 1896. Not incorporated. The annual meeting is held in Reading, Pa., on the first Tuesday in January of each year. Monthly meetings are held in the same place on the first Tuesday in each month. President, Lewis A. Schollenberger, M. D., 637 Walnut street, Reading, Pa. Secretary, Judson C. Sanders, M. D., 111 North Fifth street, Reading, Pa. Number of members, 15; admitted last year, 1; died last year, 1.

Reading Homœopathic Hospital and Dispensary Association. Organized 1887. Not incorporated. The annual meeting is held in the Homœopathic Hospital, Reading, Pa., on the third Tuesday in January of each year. Monthly meetings are held in the same place on the fourth Tuesday in each month. President, W. F. Marks, M. D., 48 North Ninth street, Reading, Pa. Secretary, Henry F. Schantz, M. D., 402 North Fifth street, Reading, Pa. Number of members, 12; admitted last year, 1; died last year, 1. Annual dues, $1.00.

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Schuylkill County Homœopathic Medical Society. It has been impossible to obtain any report from this society this year.

Texas.

San Antonio Society of Homœopathic Physicians. Organized 1901. Not incorporated. The annual meeting is held in San Antonio, Texas. Monthly meetings are held in the same place. President, Charles A. Wilson, M. D., St. James Hotel, San Antonio, Texas. Secretary, Wilbur A. Blauvelt, M. D., San Antonio, Texas. Number of members, 6.

Wisconsin.

Milwaukee Academy of Medicine. Organized 1897. Not incorporated. The annual meeting is held in Milwaukee, Wis., on the third Wednesday in April of each year. Monthly meetings are held in the same place on the third Wednesday in each month, from September to April, inclusive. President, Walter W. Irving, M. D., 121 Wisconsin street, Milwaukee, Wis. Secretary, Filip A. Forsbeck, M. D., 121 Wisconsin street Milwaukee, Wis. Number of members, 20; admitted last year, 1. Annual dues, $1.00.

HOMOEOPATHIC MEDICAL CLUBS.

Colorado.

Denver Homœopathic Club. Organized 1890. Not incorporated. The annual meeting is held in Denver, Col., on the third Monday in January. Monthly meetings are held in the same place on the third Monday in each month. President, Chauncey E. Tennant, M. D., Steele Block, Denver, Col. Secretary, Edwin Jay Clark, M. D., Steele Block, Denver, Col. Number of members, 50; admitted last year, 6. Annual dues, $1.00. Delegate, David A. Strickler, M. D. Have published the papers which were read at the meetings, in "The Critique." The following is the program for the year:

April 21st, 1902.	Sanitation of the Lying-in-room.....G. P. Howard, M. D.
	Gall Stones.....Sarah E. Calvert, M. D.
	Analysis of Urine in Diagnosis of Renal Diseases.... .....Otto G. Freyermuth, M. D.
May 19th, 1902.	Therapeutics of Appendicitis.....C. E. Tennant, M. D.
	Early Operation in Appendicitis.....W. R. Welch, M. D.
	Clinical Report. An Interesting Fracture. Illustrated.....J. Wylie Anderson, M. D.
June 16th, 1902.	Floating Kidney.....J. W. Harris, M. D.
	Lymphæmic Dyscrasia in the Child and Its Probable Entailment Upon the Adult.....A. C. Stewart, M. D.
July 21st, 1902.	Care of the Nose, Throat and Ear in the Exanthemata.....David A. Strickler, M. D.
	Why the Indicated Remedy Failed.....J. W. Mastin, M. D.
	Differential Diagnosis of the Exanthemata..... .....O. S. Vinland, M. D.
Aug. 18th, 1902.	Chronic Orethritis.....Edwin Jay Clark, M. D.
	A Case of Cannabis Indica Poisoning..... .....R. O. Butterfield, M. D.
	Electricity in Diseases of Women. Julia D. Fitz Hugh, M. D.

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Sept. 13th, 1902.	Bacteriology as Applied to Medicine and Surgery.. .....J. R. Brown, M. D.
	Prostatitis.....J. P. Willard, M. D.
	Mercurius Biniodide.....W. A. Jones, M. D.
Oct. 20th, 1902.	Some of the Prominent Urinary Disturbances, with Their Characteristic Mental Phases..C. E. Tennant, M. D.
	Specialties—Their Influence Upon the Hahnemannian Doctrine.....David A. Strickler, M. D.
	Reduction of Dislocations.....J. S. Morrow, M. D.
Nov. 17th, 1902.	Therapeutic Limits in Carcinoma of the Viscera.... .....G. P. Howard, M. D.
	Carcinoma Uteri.....W. R. Welch, M. D.
	The Microscope in Diagnosis of Malignant Disease.. .....F. P. Tuxbury, M. D.
Dec. 15th, 1902.	Unmodified Cow's Milk as a Food for the Infant or Adult in Disease.....Walter Joel King, M. D.
	A Few of the Important Phenomena Manifested as a Result of Disturbance of the Sympathetic Ganglionic Cycle.....C. W. Enos, M. D.
	Sanitary Science.....E. P. Miller, M. D.
Jan. 19th, 1903.	President's Annual Address.....C. E. Tennant, M. D.
	Reports of Secretary and Treasurer.
	Paying Dues for 1903.
	Election of Officers.
Feb. 16th, 1903.	The Mercurials versus Syphilis, in Diseases of the Myelon and General Nervous Diseases.A. C. Stewart, M. D.
	History of Surgery Since Lister's Time.G. E. Brown, M. D.
	Comparative Materia Medica.....J. W. Mastin, M. D.
Mar. 16th, 1903.	Myxœdema—Report of a Case.....S. S. Smythe, M. D.
	Bright's Disease—Medical Treatment..W. A. Burr, M. D.
	Bright's Disease—Surgical Treatment..J. W. Harris, M. D.

Connecticut.

Dunham Medical Club of Hartford. Organized 1897. Not incorporated. The annual meeting is held in Hartford Conn. Monthly meetings are held in the same place. The President is chosen at each meeting. Secretary, Hills Cole, M. D., 926 Main street, Hartford, Conn. Number of members, 16; admitted last year, 2. "This is a purely informal organization, meeting monthly, for the discussion of medical papers."

District of Columbia.

Washington Medical and Surgical Club. Organized 1892. Not incorporated. The annual meeting is held in Washington, D. C., on the third Thursday in December of each year. Monthly meetings are held in the same place on the third Thursday in each month. President, Richard Kingsman, M. D., 711 East Capitol street, Washington, D. C. Secretary Charles A. Davis, M. D., 1010 Fifteenth street, N. W., Washington, D. C. Number of members, 10. Delegate, J. B. Gregg Custis, M. D.

Georgia.

Atlanta Medical Club. Organized 1882. Not incorporated. The annual

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meeting is held in Atlanta, Ga., on the first Monday in June of each year. Monthly meetings are held in the same place on the first Monday in each month. President, Richard E. Hinman, M. D., 153 Whitehall street, Atlanta, Ga. Secretary, Clarence M. Paine, M. D., 67 North Forsyth street, Atlanta, Ga.

Maryland.

Homœopathic Medical and Surgical Club of Baltimore. Organized 1901. Not incorporated. The annual meeting is held in Baltimore, Md., on the second Wednesday in May of each year. Monthly meetings are held in the same place on the second Wednesday in each month. President, Bartus Trew, M. D., 315 North Paca street, Baltimore, Md. Secretary, William M. Pannebaker, M. D., 1209 Madison avenue, Baltimore, Md. Number of members, 14; admitted last year, 4. Annual dues, $3.00.

Massachusetts.

Hughes Medical Club of Boston. Organized 1879. Not incorporated. The annual meeting is held in Boston, Mass., on the second Friday in May of each year. Monthly meetings are held in the same place on the second Friday in each month, from October to May, inclusive. The president is chosen at each meeting. Secretary, George B. Rice, M. D., 229 Berkeley street, Boston, Mass. Number of members, 15. Annual dues, $1.00. "This club is an informal organization. We all know one another internally, and meet for scientific discussion of topics of the day."

Neighborhood Medical Club of Boston. Organized 1897. Not incorporated. The annual meeting is held at Hotel Nottingham, Boston, Mass., on the second Wednesday evening in April of each year. Monthly meetings are held in the same place on the second Wednesday evening in each month, from October to May, inclusive. The President is chosen at each meeting. Secretary, J. Tucker Cutler, M. D., 20 Cranford street, Roxbury, Mass. Number of members, 30; admitted last year, 2. Delegates, N. R. Perkins, M. D., S. H. Calderwood, M. D., W. A. Paul, M. D.

Lowell Hahnemann Club. Organized 1881. Not incorporated. The annual meeting is held in Lowell, Mass., on the first Wednesday of December of each year. Monthly meetings are held in the same place on the first Wednesday of each month, from October to June, inclusive. President, Charles H. Leland, M. D., 202 Merrimack street, Lowell, Mass. Secretary, George L. Van Deusen, M. D., 17 Kirk street, Lowell, Mass. Number of members, 10 active, 9 associate; admitted last year, 1 active, 3 associate. Annual dues, active, $2.00; associate, $1.00. Delegate, G. Forrest Martin, M. D. "Active membership is confined to residents of Lowell; associates are non-residents."

Farrington Club of Salem. Organized 1897. Not incorporated. The annual meeting is held in Salem, Mass., on the first Thursday in September of each year. Weekly meetings are held in the same place on every Thursday evening during the year.

Allen Homœopathic Materia Medica Club of Springfield. Organized 1899. Not incorporated. The annual meeting is held in Springfield, Mass. Monthly meetings are held in the same place. President, John H. Carmichael, M. D., Maple street, Springfield, Mass. Secretary, Clarice J. Parsons, M. D., St. James avenue, Springfield, Mass. Number of members, 23; admitted last year, 3. Annual dues, 50 cents. Delegate, John S. Carmichael, M. D.

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Michigan.

Detroit Homœopathic Medical Club.

Missouri.

Hahnemann Medical Club of St. Louis. Organized 1873. Not incorporated. The annual meeting is held in St. Louis, Mo., in January of each year. Semi-monthly meetings are held in the same place. The President is elected at each meeting. Secretary, James A. Campbell, M. D., 1729 Washington avenue, St. Louis, Mo. Number of members, 9; admitted last year, 1. Delegate, James A. Campbell, M. D.

New Jersey.

Atlantic City Homœopathic Medical Club. Organized 1889. Not incorporated. The annual meeting is held in Atlantic City, N. J., on the third Friday in January of each year. Monthly meetings are held in the same place on the third Friday of each month, with the exception of July and August. President, William G. Gardiner, M. D., 158 South Pennsylvania avenue, Atlantic City, N. J. Secretary, Melvern S. Lyon, M. D., 716 Atlantic avenue, Atlantic city, N. J. Number of members, 17; admitted last year, 4. Annual dues, $2.00. "The monthly meetings have been very well attended, and a paper has been read each month, with full discussion of the same. Plans are under way and legal steps have been taken to organize the Atlantic Homœopathic Hospital Association in the near future."

Communipaw Medical Club. Organized 1885. Not incorporated. Monthly meetings are held in Jersey City, N. J. President, Levings A. Opdyke, M. D., 55 Clinton avenue, Jersey City, N. J. Secretary, James Hoffman, M. D., 461 Jersey avenue, Jersey City, N. J. Number of members, 3.

Machaon Club of Jersey City. Organized 1893. Not incorporated. The annual meeting is held in Jersey City, N. J., in February of each year. Monthly meetings are held in the same place. President, T. H. Lemmery, M. D., 143 Magnolia avenue, Jersey City, N. J. Secretary, Bernard Clausen, M. D., 736 Garden street, Hoboken, N. J. Number of members, 13 regular, 3 honorary; admitted last year, 2; died last year, 1 regular, 1 honorary. Annual dues, $1.00.

New Jersey Chiron Club. Organized 1894. Not incorporated. The annual meeting is held in Newark, N. J., on the second Thursday in November of each year. Monthly meetings are held in the same place on the second Thursday of each month, from October to June, inclusive. The President is chosen at each meeting. Secretary, Edward Hill Baldwin, M. D., 77 Clinton avenue, Newark, N. J. Number of members, 15; admitted last year, 1. Annual dues, $12.00.

New Jersey Medical Club of Newark. Organized 1869. Not incorporated. The annual meeting is held in Hotel Manhattan, New York City, on the third Wednesday in March of each year. Monthly meetings are held in the same place, on the third Wednesday in each month, from October to June, inclusive. The President is elected every six months. Secretary, Charles B. Holmes, M. D., Rahway, N. J. Number of members, 14; died last year, 1.

New York.

Inter Nos Club of Brooklyn. Organized 1901. Not incorporated. The annual meeting is held at the Crescent Club, Brooklyn, N. Y., on the first Friday in October of each year. Monthly meetings are held in the same place

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on the first Friday in each month, from October to May, inclusive. Executive Officer, Magnus Tate Hopper, M. D., 46 South Oxford street, Brooklyn, N. Y. Secretary, Ralph I. Lloyd, M. D., 450 Ninth street, Brooklyn, N. Y. Number of members, 18; admitted last year, 1. Annual dues, $10.00.

Brooklyn Medical Club. Organized 1896. Not incorporated. The annual meeting is held in Brooklyn, N. Y., on the third Monday in October of each year. Monthly meetings are held in the same place on the third Monday in each month, from October to May, inclusive. The President is chosen at each meeting. Secretary, Herbert D. Schenck, M. D., 241 McDonough street, Brooklyn, N. Y. Number of members, 14; admitted last year, 1; died last year, 1. Annual dues, $16.00.

Clinical Club of Buffalo. Organized 1895. Not incorporated. The annual meeting is held in Buffalo in the month of December of each year. Semimonthly meetings are held in the same place, from October to May, inclusive. The President is chosen at each meeting. Secretary, Clayton W. Seaman, M. D., 232 Hoyt street, Buffalo, N. Y. Number of members, 25; died last year, 1. Annual dues, 50 cents. "The club meetings are very informal; clinical cases are reported. Papers are read at each meeting upon general medical topics, followed by a free discussion."

Charion Club of New York. Organized 1886. Not incorporated. The annual meeting is held in New York City on the second Monday in December of each year. Monthly meetings are held in the same place on the second Monday in each month. President, Russell P. Fay, M. D., Yonkers, N. Y. Secretary, John W. Dowling, M. D., West Forty-eighth Street, New York City. Number of Members, 20.

Clinical Club of New York. Organized 1877. Not incorporated. The annual meeting is held at "The Arena," New York City, on the third Friday in November of each year. Monthly meetings are held in the same place on the third Friday of each month, from October to May, inclusive. President, Hamilton Rickaby, M. D., 42 West Ninety-fourth Street, New York City. Secretary, Gove S. Harrington, M. D., 487 West One Hundred and Forty-third Street, New York City. Number of members, 28; admitted last year 4. Annual dues, $12.00. Delegates, George W. McDowell, M. D.; T. Franklin Smith, M. D.

Dunham Club of New York. Organized 1895. Not incorporated. The annual meeting is held in New York City on the third Saturday in January of each year. Monthly meetings are held at the residences of the different members, in rotation, on the third Saturday of each month. President, Herbert C. Allen, M. D., 304 Clermont Avenue, Brooklyn, N. Y. Secretary, Horace G. Kaith, M. D., Yonkers, N. Y. Number of members, 15. Annual dues, $1.00.

Jahr Club of New York. Organized 1876. Not incorporated. The annual meeting is held in New York City, on the first Monday in December of each year. Monthly meetings are held in the same place on the first Monday in each month.

Meissen Club of New York. Organized 1900. Not incorporated. The annual meeting is held in New York City on the third Friday in June of each year. Monthly meetings are held in the same place on the third Friday of each month, from September to June, inclusive. Secretary, John B.

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Garrison, M. D., 111 East Seventieth Street, New York City. Number of members, 24.

New York Club. Organized 1865. Not incorporated. The annual meeting is held in New York City. Monthly meetings are held in the same place. The President is chosen at each meeting. Secretary, John W. Dowling, M. D., 116 West Forty-eighth Street, New York City. Number of members, 18.

New York Homœopathic Union. Organized 1888. Not incorporated. The annual meeting is held in New York City on the third Thursday in April of each year. Monthly meetings are held in the same place on the third Thursday of each month. President, Edmund Carleton, M. D., 62 West Forty-ninth Street, New York City. Number of members, 40.

Unanimous Club of New York. Organized 1893. Not incorporated. The annual meeting is held in New York City on the last Wednesday in May of each year. Quarterly meetings are held in the same place on the last Wednesdays in October, December and March of each year. The President is chosen at each meeting. Secretary, Alton G. Warner, M. D., 19 Schermerhorn Street, Brooklyn, N. Y. Number of members, 20; admitted last year, 2. Annual dues, $20.00. Delegate, Alton G. Warner, M. D.

Ohio.

Pulte Materia Medica Club of Cincinnati. Organized 1900. Not incorporated. The annual meeting is held on the third Friday in May of each year. Semi-monthly meetings are held in the same place on the first and third Fridays of each month, from September to May, inclusive. President, Mary E. Minor, M. D., 22 East Fifth Street, Cincinnati, Ohio. Secretary, Ida E. McCormick, M. D., 3110 Woodburn Avenue, Cincinnati, Ohio. Number of members, 10; admitted last year, 2. "This year we have studied each remedy after the following plan: Botanical and chemical data, allopathic name and dose, size of toxic dose, antidotes, physiological action, pathogenesis, symptomatology, therapeutics, ameliorations and aggravations, key-note, surgical comparisons; each member of the club has been assigned a different section every time. The plan has proved both interesting and helpful."

Pennsylvania.

Oregon Club of Chester. Organized 1887. Not incorporated. The annual meeting is held in Chester, Pa., in February of each year. Semi-annual meetings are held in the same place.

Raue Medical Club. Organized 1900. Not incorporated. The annual meeting is held in different places in Central Pennsylvania, alternately, on the first Tuesday in December of each year. Monthly meetings are held in different places, alternately, on the first Tuesday in each month. President, Edward H. Morrow, M. D., 901 Seventeenth Street, Altoona, Pa. Secretary, Daniel Bohn, M. D., 1021 Seventh Avenue, Altoona Pa. Number of members, 14; admitted last year, 1. Annual dues, $1.00. Delegate, Edward H. Morrow, M. D.

Boenninghausen Club of Philadelphia. Organized 1877. Not incorporated. The annual meeting is held in Philadelphia, on the third Wednesday in November of each year. Monthly meetings are held on the third Wednesday of each month at 806 North Broad Street, Philadelphia, Pa. President, Theodore P. Gittens, M. D., 1716 Diamond Street, Philadelphia, Pa. Secre-

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tary, George W. Smith, M. D., 806 North Broad Street, Philadelphia, Pa. Number of members, 9. Annual dues, $2.00.

The J. Harwood Closson Medical Club. Organized 1898. Not incorporated. The annual meeting is held in Hotel Larrame, Philadelphia, Pa. Monthly meetings are held at the offices of the members, alternately, in Germantown, Pa. President, Gilbert J. Palen, M. D., 53 West Walnut Lane, Germantown, Philadelphia Pa. Secretary, Francis L. Hughes, M. D., 1509 North Sixth Street, Philadelphia, Pa. Number of members, 12; admitted last year, 1. Delegate, J. Harwood Closson, M. D. "A paper is read at each meeting, but it is not published."

Hahnemann Club of Philadelphia. Organized 1872. Not incorporated. The annual meeting is held in Philadelphia, Pa., on the second Tuesday in January of each year. Monthly meetings are held in the same place on the second Tuesday in each month. President, B. Frank Betts, M. D., 1609 Girard Avenue, Philadelphia, Pa. Secretary, Thomas S. Dunning, M. D., 1328 North Fifteenth Street, Philadelphia, Pa. Number of members, 10. The papers which have been read at the meetings are published in the medical journals. Delegate, Pemberton Dudley, M. D.

Oxford Medical Club of Philadelphia. Organized 1885. Not incorporated. The annual meeting is held in Philadelphia, Pa., on the first Friday in November of each year. Monthly meetings are held in the same place on the first Friday of each month, with the exception of July and August. Presiwent, T. W. Heysinger, M. D., 1521 Poplar Street, Philadelphia, Pa. Secretary, William M. Griffith, M. D., 1827 North Seventeenth Street, Philadelphia, Pa. Number of members, 18; admitted last year, 1. Annual dues, fifty cents. The paper which is read at each meeting is published in some medical journal. Delegate, T. L. Chase, M. D. "It is the boast of our Club that we always have a very full attendance at our meetings."

Philadelphia Clinical Society. Organized 1880. Not incorporated. The annual meeting is held in Philadelphia, Pa., in October of each year. Monthly meetings are held in the same place. President, Charles M. Thomas, M. D., 1623 Arch Street, Philadelphia, Pa. Secretary, William H. Bigler, M. D., 118 North Seventeenth Street, Philadelphia, Pa. Number of members, 11.

Philadelphia Medical Club. Organized 1880. Not incorporated. The annual meeting is held in Philadelphia, Pa., on the first Wednesday in January of each year. Monthly meetings are held in the same place on the first Wednesday of each month. President, Louis Plumer Posey, M. D., 1435 Walnut Street, Philadelphia, Pa. Secretary, Edwin H. Van Deuser, M. D., 2105 Tioga Street, Philadelphia, Pa. Number of members, 13. Delegates, Clarence Bartlett, M. D., William W. Van Baun, M. D.

A. R. Thomas Club of Philadelphia. Organized 1888. Not incorporated. The annual meeting is held in Philadelphia, Pa. on the second Wednesday in March in each year. Monthly meetings are held in the same place on the second Wednesday of each month. President, Oliver S. Haines, M. D., 137 North Fifteenth Street, Philadelphia, Pa. Secretary, Albert A. Norris, M. D., 4818 Chester Avenue, Philadelphia, Pa. Number of members, 21; died last year, 1.

Saturday Night Club of Microscopics of Philadelphia. Organized 1894. Not incorporated. The annual meeting is held in Hahnemann Medical College, Philadelphia, Pa, on the third Saturday evening of January of each

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year. Monthly meetings are held in the same place on the third Saturday evening in each month. President, Joseph C. Guernsey, M. D., 1923 Chestnut Street, Philadelphia, Pa. Secretary, Nathan Smilie, M. D., 1527 Chestnut Street, Philadelphia, Pa. Number of members, 64; admitted last year, 8. Annual dues, $2.00 The transactions of the meetings are published. Delegates, Joseph C. Guernsey, M. D., John J. Tuller, M. D.

William B. Van Lennep Clinical Club of Philadelphia. Organized 1895. Not incorporated. The annual meeting is held in Philadelphia, Pa., on the first Tuesday in May of each year. Monthly meetings are held in the same place on the first Tuesday in each month. President, D. Bushrod James, M. D., 2005 North Twelfth Street, Philadelphia, Pa. Secretary, J. Wyllis Hassler, M. D., 1503 Poplar Street, Philadelphia, Pa. Number of members, 15; admitted last year, 1; died last year, 1. Annual dues, $5.00. Publishes the papers which are read before the club.

Von Grauvogle Club of Philadelphia.

Woman's Homœopathic Medical Club of Philadelphia. Organized 1883. Not incorporated. The annual meeting is held at 1719 Arch Street, Philadelphia, Pa., on the first Tuesday in November of each year. Monthly meetings are held at the offices of the different members, alternately, on the first Tuesday in each month. President, Julia G. Waylan, M. D., 1832 Tioga Street, Philadelphia, Pa. Secretary, Margaret C. Lewis, M. D., 4027 Spring Garden Street, Philadelphia, Pa. Number of members, 15; admitted last year, 1. "Very interesting as well as instructive meetings have been held during the year. At each meeting a single disease, or a group of diseases, has been taken up for consideration. Papers on etiology, pathology, symptoms, etc., have been read, followed by a general discussion, and reports of interesting clinical cases."

Wisconsin.

Central Wisconsin Medical Club. Organized 1901. Not incorporated. Quarterly meetings are held in different places in Central Wisconsin, on the first Tuesdays in September, December, March and June of each year. President, W. H. Titus, M. D., Oshkosh, Wis. Secretary, H. E. Johnston, M. D., Oshkosh, Wis. Number of members, 25. Annual dues $2.00. "Our club is small but energetic and promising."

ALUMNI ASSOCIATIONS.

Alumni Association of the Southern Homœopathic Medical College of Baltimore. Organized 1892. Not incorporated. The annual meeting is held in Baltimore, Md., on "Commencement Day."

Alumni Association of the Boston University School of Medicine. Organized 1870. Incorporated 1900. The annual meeting is held in Boston, mass., on "Commencement Day." President, J. Emmons Briggs, M. D., 206 Huntington Avenue, Boston, Mass. Secretary, David W. Wells, M. D., "The Westminster," Copley Square Boston, Mass. Number of members, 756; admitted last year, 25; died last year, 7. Annual dues, $1.00. Delegates, John P. Sutherland, M. D., Howard P. Bellows, M. D.

Alumni Association of the Homœopathic College of the University of Michigan. Organized 1878. Incorporated 1878. The annual meeting is

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held in Ann Arbor, Mich., on "Commencement Day." President, John M. Lee, M. D., Rochester, N. Y. Number of members, 350.

Alumni Association of the New York Homœopathic Medical College and Hospital. Organized 1883. Incorporated 1899. The annual meeting is held in New York City on "Commencement Day." President, E. H. Linnell, M. D., Norwich, Conn. Secretary, A. Worrall Palmer, M. D., 210 West Fifty-seventh Street, New York City. Number of members, 627; admitted last year, 42; died last year, 9. Annual dues, $1.00.

Alumni Association of the New York College and Hospital for Women. Organized 1863. Incorporated 1863. The annual meeting is held in New York City on "Commencement Day." President, Katherine G. Townsend, M. D., 354 West One Hundred and Twenty-third Street, New York City. Secretary, Harriet B. Van Buren, M. D., 126 Halsey Street, Brooklyn, N. Y. Number of members, 150; admitted last year, 8; died last year, 1. Annual dues, $1.00.

Alumni Association of the Ward's Island and Metropolitan Hospitals, New York City. Organized 1896. Incorporated 1896. The annual meeting is held in New York City on the first Wednesday in December of each year. President, Henry M. Bunting, M. D., Morristown, Pa. Secretary, Ephraim D. Klots, M. D., 132 West Forty-seventh Street New York City. Number of members, 162. Admitted last year, 4; died last year, 2. Annual dues, $3.00. It has published during the last year an appendix to the history of the hospital.

Alumni Association of Pulte Medical College. Organized 1878. Not incorporated. The annual meeting is held in Cincinnati, Ohio, on "Commencement Day." President, Frank Webster, M. D., Dayton, Ohio. Secretary, Charles E. Geiser, M. D., 1511 Baymiller Street, Cincinnati, Ohio. Number of members, unknown; admitted last year, 10.

Alumni Association of Hahnemann College of Philadelphia. Organized 1857. Not incorporated. The annual meeting is held in Philadelphia, Pa., on "Commencement Day." President, Alonzo P. Williamson, M. D., Minneapolis, Minn. Secretary, Woodward D. Carter, M. D., 1533 South Fifteenth Street, Philadelphia, Pa. Number of members, 1,502; admitted last year, 74; died last year, 14.

MISCELLANEOUS HOMOEOPATHIC ASSOCIATIONS.

The Meissen. Organized 1893. Not incorporated. The annual meeting is held in the same place and at the same time as the American Institute of Homœopathy. President, Mrs. William H. Vanden Burg, 32 West Forty-ninth Street, New York City. Secretary, Miss Emily F. Paine, 6 East Forty-seventh Street, New York City. Number of members, 230. Annual dues, $1.00. "The Meissen is a club, organized for the purpose of promoting sociability and acquaintance among the members of the Institute and their friends."

The New England Hahnemann Association. Organized 1895. Incorporated 1896. The annual meeting is held in Boston, Mass., on the second Monday in January of each year. President, Edmund S. Whitman, Pemberton Building, Boston, Mass. Secretary, George V. S. Michaelis, Globe Building,

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Boston, Mass. Number of members, 374. Annual dues, $2.00. Delegate, Horace Packard, M. D.

Homœopathic Pharmaceutical Association of Pennsylvania. Organized 1881. Incorporated 1881. The annual meeting is held in Philadelphia, Pa. President, Frank J. Slough, M. D., Allentown, Pa. Secretary, E. P. Anschutz, Box 921, Philadelphia, Pa. Number of members, 13.

GENERAL HOMŒOPATHIC HOSPITALS IN THE UNITED STATES.

Alaska.

Sitka Mission Hospital, Sitka. Not incorporated. Opened for patients 1889. Number of beds, 30. Number of patients treated last year, 189. Out door patients, 2,130. Executive Officer, Miss Esther Gibson, Sitka, Alaska. Estimated value of hospital property, $10,000. Supported principally from Woman's Board of Missions of the Presbyterian Church.

California.

Fabiola Hospital Association, Homœopathic Department, Oakland, Cal. Incorporated 1877. Opened for patients 1877. Executive Officer, Mrs. John Yule, Chicago Avenue, Okland, Cal. Number of beds, 100. Number of patients treated last year, 774. Estimated value of hospital property, $75,000. Supported by fees from patients, nurses' earnings and private contributions. "Physicians of all schools bring their patients here, and we are unable to give the number treated in any one department."

Good Samaritan Hospital, San Diego, Cal. Not incorporated. Opened for patients 1889. Executive Officer, Thomas Docking, M. D., 112 Boston Avenue, San Diego, Cal. "The hospital is still closed temporarily, but we think that it will be reopened in a very short time."

Canada.

Montreal Homœopathic Hospital, Montreal, Can. Not incorporated. Opened for patients 1893. Executive officer, Miss E. Rose Lorenz. Number of beds, 40. Number of patients treated last year, 221. Value of hospital property, $30,000. Supported by pay of private patients, endowment of $12,000 and public subscriptions. Attending physician, Alexander R. Griffith, M. D., 763 Wellington street, Montreal, Can.

Colorado.

Arapahoe County Hospital, Homœopathic Department, Denver, Colo. Incorporative executive officer, William A. Shuiff, at the hospital. Number of beds, 300. Number of patients treated last year 1,435. Value of hospital property, $500,000. Supported by county appropriation. Delegate, David A. Strickler, M. D. "This hospital has two staffs, one old school, one homœopathic; the patients are divided pro rata."

Denver Homœopathic Hospital, Denver, Colo. Incorporated 1894. Opened for patients 1895. Executive officer, Chauncey E. Tennant, M. D., Steele block, Denver, Colo. Number of beds, 28. Number of patients treated last year, 300. Of these 190 were private patients and 110 were ward patients. Value of hospital property, $35,000. Supported by hospital and college fees. Delegate, David A. Strickler.

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Connecticut.

Grace Homœopathic Hospital, New Haven, Conn. Incorporated 1888. Opened for patients 1892. Executive officer, Emory J. Walker, M. D., 1136 Chapel street, New Haven, Conn. Number of beds, 75. Number of patients treated last year, 458. Value of hospital property, $100,000. Supported by fees of patients, state appropriations and voluntary contributions.

Delaware.

Homœopathic Hospital of Delaware, Wilmington, Del. Incorporated 1888. Opened for patients 1888.

District of Columbia.

National Homœopathic Hospital Association, Washington, D. C. Incorporated 1881. Opened for patients 1884. Executive officer, Ralph Jenkins, M. D., 1732 Massachusetts avenue, N. W., Washington, D. C. Number of beds, 50. Number of patients treated last year, 1,114, divided as follows: Medical, 408; obstetrical, 63; surgical, 643. Value of hospital property, $50,000. Supported by Congressional appropriation, income from private rooms, income from nursing, private donations and subscriptions.

Florida.

St. Luke's Hospital, Jacksonville, Fla., Homœopathic Department. Incorporated 1882. Opened for patients 1882. Number of patients treated last year, 4. Supported by donations and fees from private patients. Delegate, Henry R. Stout, M. D.

Illinois.

Cook County Hospital, Homœopathic Department, Chicago, Ill. Incorporated 1865. Opened for patients 1865.

Hahnemann Hospital, Chicago, Ill. Incorporated 1855. Opened for patients 1870. Ex-officer, George F. Shears, M. D., 3130 Indiana avenue, Chicago, Ill. Number of beds, 170. Number of patients treated last year, 1,305. Value of hospital property, $200,000. Supported by endowments, donations and pay of private patients. Delegate, George F. Shears, M. D. "The hospital is in a very prosperous condition. Additions to endowment fund are being constantly received. The enlargement of the building is demanded to meet the constantly increasing demand for private rooms, and is now under consideration by the Board of Trustees."

Chicago Homœopathic Hospital, Chicago, Ill. Incorporated 1876. Opened for patients 1876. Executive officer, W. E. Fruitt, M. D., Chicago, Ill. Number of beds, 40. Number of patients treated last year, 448. Value of hospital property, $25,000. Supported by pay of private patients, endowments and voluntary contributions. Delegate, Edwin H. Pratt, M. D.

Iowa.

Homœopathic Hospital of the State University of Iowa. Incorporated 1887. Opened for patients 1887. Executive officer, James G. Gilchrist, M. D., 125 College street, Iowa City, Iowa. Number of beds, 64. Number of patients treated last year, 420. Value of hospital property, $60,000. Supported by State appropriations and fees of patients. Delegate, George Royal, M. D.

St. Bernard's Hospital, Homœopathic Department, Council Bluffs, Iowa. Incorporated 1888. Opened for patients 1888.

Woman's Christian Association Hospital, Homœopathic Department,

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Council Bluffs, Iowa. Incorporated 1894. Opened for patients 1884. Executive officer, Miss M. E. S. Pinney. Number of beds, 30. Number of patients treated last year, 75. Value of hospital, $30,000. Supported by County appropriation, voluntary contributions and pay of patients. Delegate, Alfred P. Hanchett, M. D.

Samaritan Hospital and Training School for Nurses, Sioux City, Iowa. Incorporated 1894. Opened for patients 1894. Executive officer, Mrs. W. Stinson, Sioux City, Iowa. Number of beds, 70. Number of patients treated last year, 614. Value of hospital property, $25,000. Supported by board of patients. Delegate, A. Perry Bowman, M. D. "This institution is controlled by the Woman's Christian Association, and is open to physicians of all schools. The attending staff is composed of homœopathic and allopathic physicians, as is the corps of lecturers to the Training School."

Kentucky.

City Hospital, Homœopathic Department, Louisville, Ky. Incorporated 1882. Opened for patients 1882. Executive officer, Ellis Duncan, M. D., City Hospital, Louisville, Ky. Number of beds, 200. Number of patients treated last year, 3,000. Value of hospital property, $750,000. Supported by taxation. Delegate, George S. Coon, M. D. "One-sixth of the patients are under homœopathic treatment."

Southwestern Homœopathic Hospital, Louisville, Ky. Incorporated 1892. Opened for patients 1893.

Maryland.

Maryland, Homœopathic Hospital, Baltimore, Md. Incorporated 1890. Opened for patients 1893. Executive officer, John T. Graham, 223 St. Paul street, Baltimore, Md. Number of beds, 55. Number of patients treated last year, 783. Value of hospital property, $48,000. Supported by city and State appropriations and private contributions. Delegate, Henry Chandlee, M. D. "We are gradually [illegible] ourselves known and respected in the city of Baltimore."

[illegible]achusetts.

Massachusetts H[illegible] Hospital, Boston, Mass. Incorporated 1855. Opened for patients [illegible] tive officer, William O. Mann, M. D., East Concord street, Bost[illegible] umber of beds, 220. Number of patients treated last year, 2,[illegible] of hospital property, $500,000. Supported by endowment and p[illegible]s. Delegate, William O. Mann, M. D.

Brockton City H[illegible] [illegible]œopathic Department, Brockton, Mass. Incorporated 1890. O[illegible] tients 1896. Executive officer, George H. Gould, Brockton, M[illegible] of beds, 30. Number of patients treated last year, 366. Val[illegible] property, $50,000. Supported by board of patients, city approp[illegible]ate subscriptions. "There is a dual staff; patients are given [illegible]g physicians alternately. Of the visiting staff there are twel[illegible]o of them being homœopaths; of the consulting staff there [illegible]bers, two of them are homœopaths; of the special consulting [illegible] are three members, one of them being a homœopath.

Rufus S. Fros[illegible]ospital, Homœopathic Department, Chelsea, Mass. Incorporat[illegible]d for patients 1890. Executive officer, E. F. Guild, [illegible] Chelsea, Mass. Number of beds, 50. Num-

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ber of patients treated last year, 389. Value of hospital property, $30,000. Supported by city appropriations, Frost free bed and earnings. Delegate, J. Edward Blaisdell, M. D. "Patients are equally divided between the physicians of the two schools of medicine, unless a preference is made by the patient. Since the hospital has been opened there has been nothing but the most pleasant relations existing between the physicians of the two schools of medicine. Everything works in the most perfect harmony, without the slightest friction."

Lowell General Hospital, Homœopathic Department, Lowell, Mass. Incorporated 1891. Opened for patients 1898. Executive officer, Miss Helen M. Garrett, matron, Lowell, Mass. Number of beds, 42. Number of patients treated last year, 392. Value of hospital property, $50,000. Supported by endowments, pay of patients, Ladies' Aid Association, church donations, etc. Delegate, C. Forrest Martin, M. D. "No separate account is kept of the number of patients treated by the physicians of the two schools of medicine; the number given is that of the total number treated."

Malden Hospital, Homœopathic Department, Malden, Mass. Incorporated 1890. Opened for patients 1892. Executive officer, E. F. Bickford, M. D., care of B. R. S. Co., Malden, Mass. Number of beds, 22. Number of patients treated last year, 31. Value of hospital property, $80,000. Supported by product of farm, invested funds, paying patients and gifts. "Last year we admitted 319 patients; we have physicians of both schools of medicine on our visiting staff; a much larger number of the old school are on the staff. In giving the number of beds, one-half of the total number have been given as being given to the homœopathic physicians; the number of patients treated, as given, have been treated by the homœopaths."

Newton Hospital, Homœopathic Department, Newton, Mass. Incorporated 1881. Opened for patients 1886. Executive officer, Edward P. Scales, M. D., Newton, Mass. Number of beds, 150. Number of patients treated last year: Medical 454, surgical 367; total 821. Value of hospital property, $159,000. Supported by donations, hospital Sunday, endowment funds, board and care of patients, services of nurses. Delegate, George H. Talbot, M. D., Newtonville, Mass. "About one-third of the patients are under homœopathic treatment. The officers and administration are amicably mixed and perfectly harmonious between the physicians of the two schools."

City Hospital of Quincy, Homœopathic Department, Quincy, Mass. Incorporated 1889. Opened for patients 1890. Executive officer, Timothy Reed, Quincy, Mass. Number of beds, 25. Number of patients treated last year, 268—medical, 107; surgical, 161. Value of hospital property, $30,000. Supported by an endowment fund of $45,000, city appropriations, pay of patients and voluntary contributions. Delegate, Henry C. Hallowell, M. D.

Somerville Hospital, Homœopathic Department, Somerville, Mass. Incorporated 1891. Opened for patients 1893.

Hampden Homœopathic Hospital, Springfield, Mass.

Springfield Hospital, Homœopathic Department, Springfield, Mass. Incorporated 1900. Opened for patients 1900. Executive officer, Miss Bertha M. Hammond, Springfield, Mass. Number of beds, 30. Number of patients treated last year, 230. Value of hospital property, $75,000. Supported by contributions and pay of patients. Delegate, John H. Carmichael, M. D.

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Worcester Hahnemann Hospital, Worcester, Mass. Incorporated 1896. Opened for patients 1896. Executive officer, Edward B. Miles, Springfield, Mass. Number of beds, 12. Number of patients treated last year, 62. Value of hospital property, $25,000. Supported by subscriptions, donations, interest on small fund and pay of patients. Delegate, Lamson Allen, M. D.

Michigan.

Homœopathic Hospital, University of Michigan, Ann Arbor, Mich. Incorporated 1874. Opened for patients 1875. Executive officer, R. E. Atchison, Ann Arbor, Mich. Number of beds, 95. Number of patients treated last year, 1,900. Value of hospital property, $125,000. Supported by State appropriations. Delegate, Royal S. Copeland, M. D.

The Grace Hospital, Detroit, Mich. Incorporated 1888. Opened for patients 1888. Executive officer, A. T. Putman, Detroit, Mich. Number of beds, 125. Number of patients treated last year, 1,193. Value of hospital property, $250,000. Supported by an endowment fund of $300,000.

Muskegon City Hospital, Muskegon. Incorporated 1892. Opened for patients 1892.

Minnesota.

City Hospital, Homœopathic Department, Minneapolis, Minn.

City and County Hospital, Homœopathic Department, St. Paul, Minn. Incorporated 1875. Opened for patients 1875. Executive officer, A. B. Aucker, M. D., St. Paul, Minn. Number of beds, 250. Number of patients treated last year, 4,000. Value of hospital property, $300,000. Supported by city and County appropriations and pay of private patients. "The hospital is open for homœopathic physicians for one in every four patients, but no comparative statistics are made." Delegate, Warren S. Briggs, M. D.

St. Joseph's Hospital, Homœopathic Department, St. Paul, Minn. Incorporated 1854. Opened for patients 1854. Executive officer, Mother Bernardine, St. Paul, Minn. Number of beds, 130. Number of patients treated last year, 1,432. Value of hospital property, $150,000. Supported by pay of patients. "There is a homœopathic medical and surgical staff."

St. Luke's Hospital, Homœopathic Department, St. Paul, Minn.

Missouri.

Kansas City Homœopathic Hospital, Kansas City, Mo. Incorporated 1900. Opened for patients 1899. Executive officer, Mrs. W. E. Dockson, Kansas City, Mo. Number of beds, 12. Number of patients treated last year, 125. Value of hospital property, $6,000. Supported by pay of patients.

Hospital for Women and Children, Homœopathic Department, Kansas City, Mo. Incorporated 1897. Opened for patients 1897.

Good Samaritan Homœopathic Hospital and Asylum of St. Louis, Mo. Incorporated 1858. Opened for patients 1858. Executive officer, William G. Mueller, Second and Washington avenues, St. Louis, Mo. Number of beds, 90. Number of patients treated last year, 358. Value of hospital property, $45,000. Supported by endowments and pay of patients. Delegates, T. Griswold Comstock, M. D.; Willis B. Morgan, M. D.; James A. Campbell, M. D.

St. Louis Children's Hospital, St. Louis, Mo. Incorporated 1879. Opened for patients 1880.

New Jersey.

West Jersey Homœopathic Hospital for Women and Children, Camden, N. J. Incorporated 1887. Opened for patients 1887.

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Passaic General Hospital, Homœopathic Department, Passaic, N. J. Incorporated 1893. Opened for patients 1897.

St. Mary's Hospital, Passaic, N. J. Incorporated 1895. Opened for patients 1895. Executive officer, Sister Rose Vincent, St. Mary's Hospital, Passaic, N. J. Number of beds, 50. Number of patients treated last year, 236. Value of hospital property, $60,000. Supported by County appropriations and voluntary contributions. Attending physician, Charles A. Church, M. D., Passaic, N. J.

Trenton Homœopathic Hospital, Trenton, N. J. Incorporated 1887. Opened for patients 1888.

New York.

Albany City Homœopathic Hospital, Albany, N. Y. Incorporated 1867. Opened for patients 1868.

Brooklyn Homœopathic Hospital, Brooklyn, N. Y. Incorporated 1852. Opened for patients 1858.

Memorial Hospital for Women and Children, Brooklyn, N. Y. Incorporated 1883. Opened for patients 1881. Executive officer, Mrs. A. W. Tift, Clarendon Hotel, Brooklyn, N. Y. Number of beds, 74. Number of patients treated last year, 688. Value of hospital property, $140,000. Supported by voluntary contributions, pay of patients and city appropriations.

Buffalo Homœopathic Hospital, Buffalo, N. Y. Incorporated 1872. Opened for patients 1872. Executive officer, Mrs. Charles J. Worth, 51 Johnson Park, Buffalo, N. Y. Number of beds, 61. Number of patients treated last year, 514. Value of hospital property, $32,000. Supported by interest from endowment fund, care of patients and donations. "During the year 96 surgical operations have been performed, of which 61 came under the head of major work, 6 of which died. The total number of deaths in the hospital was 39, giving a death rate of 7.39 per cent; 174 ambulance calls were answered, of which 122 were regular, 38 hurry and 14 transfers.

Erie County Hospital, Homœopathic Department, Buffalo, N. Y. Incorporated 1895. Executive officer, E. J. Gilroy, M. D., Erie County Hospital, Buffalo, N. Y. Number of beds, 400. Number of patients treated last year, 1,911. Value of hospital property, $580,000. Supported by city and county appropriations. Delegate, De Witt G. Wilcox, M. D. "This hospital is the city and county institution. The patients are not treated in separated departments (homœopathic and allopathic), but the homœopathic attendant takes his turn in treating all of the patients of the institution. The homœopaths have three months of the year."

Thanksgiving Hospital, Homœopathic Department, Cooperstown, N. Y. Incorporated 1868. Opened for patients 1866. Executive officer, E. S. Brockham, Cooperstown, N. Y. Number of beds, 12. Number of patients treated last year, 70. Value of hospital property, $12,000. Supported by interest on investments, donations and pay of patients. "The hospital is non-sectarian, and is not confined to either or any particular school of medicine. All local physicians belong to the medical staff."

Geneva City Hospital, Homœopathic Department, Geneva, N. Y. Incorporated 1889. Opened for patients 1889.

Flagler Hospital, Lockport, N. Y. Not incorporated. Opened for patients 1889. Executive officer, J. R. Compton, M. D., Lockport, N. Y. Number of

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beds, 5. Number of patients treated last year, 23. Value of hospital property, $3,000. Supported by pay of patients and city appropriations. "This hospital is kept open for emergency cases, for care of which the city allows $5 per week each."

Homœopathic Hospital and Dispensary, Mount Vernon, N. Y. Executive officer, J. A. House, M. D., Mount Vernon, N. Y. "The hospital is still unopened for patients."

New York Homœopathic Medical College Hospital, New York City. Incorporated 1856. Opened for patients 1890. Executive officer, George W. Clark, 10 East One Hundred and Thirtieth street, New York City. Number of beds, 100. Number of patients treated last year, 4,996. Value of hospital property, $350,000. Supported by endowments, subscriptions and receipts from paying patients.

Hahnemann Hospital, New York City. Incorporated 1869. Opened for patients 1869. Executive officer, John H. Thompson, M. D., 36 East Thirtieth street, New York City. Number of beds, 136. Number of patients treated last year, 831. Value of hospital property, $165,000. Supported by private patients, voluntary contributions, donations and invested funds. Delegate, John H. Thompson, M. D.

Laura Franklin Free Dispensary for Children, New York City. Executive officer, Frederick D. Weekes, 45 William street, New York City. Number of beds, 70. Number of patients treated last year, 343. Value of hospital property, $150,000. Supported by endowment and voluntary contributions.

Metropolitan Hospital, Blackwell's Island, New York City. Not incorporated. Opened for patients 1875. Executive officer, Homer Folks, Commissioner of Department of Public Charities, foot of East Twenty-sixth street, New York City. Number of beds, 653. Number of patients treated last year, 4,379. The property is owned by the city of New York, and is supported by city appropriation. Delegate, T. Franklin Smith, M. D. "A phthisis ward has recently been opened in a separate building from the main hospital, and it is expected that an appropriation will be made to build and fully equip some pavilions, and when this is done we shall have one of the best and largest, and best equipped phthisis hospital in this country. During the few months, since the new ward was opened, the success in caring for and in benefiting the patients there has been exceedingly satisfactory. We are looking for great results in the treatment of this disease, when we shall have the new pavilions built."

New York Medical College and Hospital for Women, New York City. Incorporated 1863. Opened for patients 1864. Executive officer, Mrs. H. L. Bender, 816 Marcy avenue, Brooklyn, N. Y. Number of beds, 50. Number of patients treated last year, 148. Value of hospital property, $122,000. Supported by Board of Patients, annual donations and subscriptions. Delegate, M. Belle Brown, M. D. "We hope and expect to treat very many more patients during the coming year, as we expect to have an up-to-date hospital in every particular."

Hargous Memorial Hahnemann Hospital, Rochester, N. Y. Incorporated 1887. Opened for patients 1889.

Rochester Homœopathic Hospital, Rochester, N. Y. Incorporated 1887. Opened for patients 1889. Executive officer, Granger A. Hollister, Rochester,

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N. Y. Number of beds, 125. Number of patients treated last year, 1,646. Value of hospital property, $249,000. Supported by voluntary contributions and pay of patients. Delegate, Edwin H. Wolcott, M. D.

Syracuse Homœopathic Hospital, Syracuse, N. Y. Incorporated 1895. Opened for patients 1897. Executive officer, E. Elmer Keeler, M. D., 452 South Saline street, Syracuse, N. Y. Number of beds, 14. Supported by pay of patients and voluntary contributions. Delegate, E. Elmer Keeler, M. D.

Utica Homœopathic Hospital, Utica, N. Y. Incorporated 1895. Opened for patients 1895. Executive officer, George S. Dana, 160 Park avenue, Utica, N. Y. Number of beds, 10. Number of patients treated last year, 169. Value of hospital property, $25,000. Supported by pay of patients and donations.

Ohio.

Ohio Hospital for Women and Children, Cincinnati, Ohio. Incorporated 1881. Opened for patients 1882. Executive Officer, Mrs. Robert House, Clifton, Cincinnati, Ohio. Number of beds, 21. Number of patients treated last year, 109. Value of hospital property, $25,000. Supported by membership dues, bequests, entertainments, endowment fund, voluntary subscriptions. Delegate, Ellen M. Kirk, M. D.

City Hospital, Homœopathic Department, Cleveland, Ohio. Number of beds, 282. "This hospital is open to physicians of both schools of practice. A movement is on foot to have a complete Homœopathic Staff; one has been formed, and arrangements are being made to have it formally appointed by the Director of Public Charities. A recent decision of the Supreme Court has, however, annulled the law under which the Director holds his office; hence nothing can be done until after a new law is passed. This will very soon be done, and then we shall be all right."

Cleveland Homœopathic Hospital, Cleveland, Ohio. Incorporated 1867. Opened for patients, 1867. Executive Officer, Harlan Pomeroy, M. D., Cleveland, Ohio. Number of beds, 100. Number of patients treated last year, 1,413. Value of hospital property, $200,000. Supported by donations and pay of patients. Delegates, David H. Beckwith, M. D.

Mitchell Thomas Hospital, Homœopathic Department, Springfield, Ohio. Incorporated 1886. Opened for patients 1886. Executive Officer, Mrs. Barnett, Mitchell Thomas Hospital, Springfield, Ohio. Number of beds, 33. Number of patients treated last year, 365. Value of hospital property, $15,000. Supported by tax, and an endowment fund of $100,000. Delegate, Harry T. Miller, M. D. "This hospital is the only one known where the Medical Staff is composed entirely of physicians of the old school, and the Surgical Staff entirely of physicians of the Homœopathic school; all work in perfect harmony. A fifty thousand dollar hospital will soon be constructed."

Toledo Hospital, Homœopathic Department, Toledo, Ohio. Incorporated 1876. Opened for patients 1876. Executive Officer, Mrs. A. E. Scott, 721 Ontario street, Toledo, Ohio. Number of beds, 110. Number of patients treated last year, 996. Value of hospital property, $140,000. Supported by board of patients and donations. Delegates, Lewis K. Maxwell, M. D.; William C. Humphrey, M. D. "A Training School of thirty is connected with the hospital, and an Annex with twenty rooms, operating rooms, etc., is just completed."

Mahoning Valley Hospital, Homœopathic Department, Youngstown, Ohio.

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Zanesville City Hospital, Homœopathic Department, Zanesville, Ohio. Incorporated 1888. Opened for patients 1891.

Deaconess Hospital, Dayton, Ohio.

Pennsylvania.

Children's Homœopathic Hospital of Philadelphia, Pa. Incorporated 1877. Opened for patients 1877. Executive Officer, Walter Strong, M. D., Philadelphia, Pa. Number of beds, 58. Number of patients treated last year, 370 in the wards, and 1,901 emergency cases treated in the hospital. Value of hospital property, $118,000. Supported by State appropriation and voluntary contributions. Delegate, N. F. Lane, M. D., 1435 Poplar street, Philadelphia, Pa.

Hahnemann Medical College Hospital, Philadelphia, Pa. Incorporated 1869. Opened for patients 1871. Executive Officer, Charles Mohr, M. D., Oak Lane, Philadelphia, Pa. Number of beds, 200. Number of patients treated last year, 1,982. In addition to these we treated 10,846 patients in emergency wards. Value of hospital property, $1,015,000. Supported by endowments, revenue from patients, State appropriations, and voluntary contributions. Delegate, Charles Mohr, M. D.

Medical, Surgical and Maternity Hospital of the Woman's Homœopathic Association of Pennsylvania, Philadelphia, Pa. Incorporated 1882. Opened for patients 1883. Executive Officer, Mrs. F. B. Skinner, Provident Building, Philadelphia, Pa. Number of beds, 80. Number of patients treated last year, 813. The mortality rate was 3.58 per cent; deducting those cases who died within twenty-four hours after admission, the death rate was 1.39 per cent. Value of hospital property, $300,000. Supported by a small endowment fund, annual subscriptions, voluntary donations, and a small State appropriation. "The number of accident cases brought in by the patrol has been 134 in excess of any previous year. Of the 29 deaths occurring in the institution, 18 have been due to fatalities thus brought to us, having died within twenty-four hours after admission; and after deducting this number, we find that our mortality rate is only 1.39 per cent. No doubt, the increase in work done would be even more apparent were it not for the fact that we are located in the ward where the recent small-pox scare originated and reached its most alarming proportions."

St. Luke's Homœopathic Hospital, Philadelphia, Pa. Incorporated 1896. Opened for patients 1896. Executive Officer, Miss Mary E. Lewars, 84 Fisher's Lane, Philadelphia, Pa. Number of beds, 29. Number of patients treated last year, 409. Value of hospital property, $32,000. Supported by voluntary contributions. Delegate, A. M. Barnes, M. D., 3517 North Broad street, Philadelphia, Pa.

Woman's Southern Homœopathic Hospital, Philadelphia, Pa. Incorporated 1896. Opened for patients 1896. Executive Officer, Miss Annie M. Miller, 1911 Mount Vernon street, Philadelphia, Pa. Number of beds, 33. Number of patients treated last year, 171. Value of hospital property, $19,500. Supported by voluntary contributions.

Homœopathic Medical and Surgical Hospital of Pittsburg, Pa. Incorporated 1866. Opened for patients 1866. Executive Officer, P. K. Bectel, Homœopathic Hospital, Pittsburg, Pa. Number of beds, 125. Number of patients

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treated last year, 2,614. Value of hospital property, $275,000. Supported by State appropriation, pay of patients, and voluntary contributions. Delegate, James H. McClelland, M. D.

Homœopathic Medical and Surgical Hospital of Reading, Pa. Incorporated 1890. Opened for patients 1891. Executive Officer, W. W. Light, Reading, Pa. Number of beds, 22. Number of patients treated last year, 175. Accidental emergency cases, 690. Value of hospital property, $35,000. Supported by State appropriations, private patients, donations, and private subscriptions. Delegate, L. A. Schollenberger, M. D. "Being centrally located, we have quite a number of accident cases, many of which might be committed to the hospital, and thus swell the number of its patients, but our rooms and beds are limited."

Hahnemann Hospital, Scranton, Pa. Incorporated 1897. Opened for patients 1897. Executive Officer, Mrs. Lucy R. Sanderson, Scranton, Pa. Number of patients treated the last year, 39—319 in-patients and 310 out-patients. Of the in-patients 115 were medical, and 204 were surgical cases; 127 operations were performed, of whom 41 were major ones and 86 were minor ones; 12 maternity cases were cared for, and 9 births occurred in the hospital. There were 1,780 prescriptions dispensed. Of these 1,082 were for in-patients and 698 for out-patients. Patients received thirty-two visits after being removed to their homes. There were twenty-four ambulance calls, all of which were supplied. Delegate, J. W. Coolidge, M. D. "The training class connected with this institution now consists of nine members. There were thirty applicants, and six of these have been accepted into the school. There have been twenty calls for nurses, twelve of which were supplied and eight refused."

Wisconsin.

St. Mary's Hospital, Milwaukee. Homœopathic Department, Milwaukee, Wis. Opened for patients 1861. Executive Officer, Sister Lucia, St. Mary's Hospital, Milwaukee, Wis. Number of beds, 100. Number of patients treated last year, 57. Value of hospital property, $150,000. Supported by charity and hospital fees. Delegates, Oscar W. Carlson, M. D., Philip Forsbeck, M. D.

PRIVATE AND SPECIAL HOMŒOPATHIC HOSPITALS IN THE UNITED STATES.

Arkansas.

Keeley Institute, Hot Springs, Ark. Not incorporated. Opened for patients 1891. Executive Officer, Robert J. Huntington, M. D., Hot Springs, Ark. Number of beds, 25. Number of patients treated last year, 90. Value of hospital property, $15,000. Supported by pay of patients. Robert M. Huntington, M. D., Manager and Physician in charge.

California.

Southern California State Hospital, Patton Cal. Incorporated 1893. Opened for patients 1893. Executive Officer, Merritt B. Campbell, M. D., Patton, Cal. Number of beds, 750. Number of patients treated last year, 923. Value of hospital property, $500,000. Supported by pay of patients, sale of oranges, and State appropriation. Delegate, Merritt B. Campbell, M. D.

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Illinois.

Deaconess Hospital, Homœopathic Department, Bloomington, Ill. Attending physician, William E. Nieberger, M. D., Bloomington, Ill. Number of beds, 31. "This hospital is open to physicians of both schools of practice."

Streeter's Hospital, Chicago, Ill. Incorporated 1888. Opened for patients 1888. Executive Officer, John W. Streeter, M. D., 2001 Prairie avenue, Chicago, Ill. Number of beds, 30. Number of patients treated last year, 478. Value of hospital property, $60,000. Supported by fees of patients. Delegate, John W. Streeter, M. D.

Luella Day Membership Hospital, Chicago, Ill. Number of beds, 15. We have been unable to obtain any report from this hospital this year.

National Temperance Hospital, Homœopathic Department, Chicago, Ill. Incorporated 1886. Opened for patients 1886.

Chicago Baptist Hospital, Homœopathic Department, Chicago, Ill.

Englewood Union Hospital and Dispensary, Englewood, Ill. Incorporated 1895. Opened for patients 1896.

St. Joseph's Hospital, Homœopathic Department, Joliet, Ill.

Moline City Hospital, Moline, Ill. Incorporated 1896. Opened for patients 1898. Executive Officer, G. Arthur Stephens, Moline, Ill. Number of beds, 40. Value of hospital property, $40,000. Supported by tax and receipts from patients. Attending physician, August H. Arp, M. D., Moline, Ill.

Rockford Hospital, Rockford, Ill. Incorporated 1883. Opened for patients 1883. Executive Officer, Wait Talcott, Rockford, Ill. Number of beds, 30. Number of patients treated last year, 502. Value of hospital property, $35,000. Supported by private patients, donations, permanent invested fund. "An addition is to be made this summer to the hospital, to be valued at about forty-five thousand dollars."

Illinois North Hospital for the Insane, Elgin, Ill. Incorporated 1870. Opened for patients 1872. Executive Officer, Frank S. Whitman, M. D., Elgin, Ill. Number of beds, 1,200. Number of patients treated last year, 1,600. Value of hospital property, $900,000. Supported by State appropriation. "This hospital has not been set apart by the legislature as a Homœopathic Institution."

Illinois Western Hospital for the Insane, Watertown, Ill. Incorporated 1895. Opened for patients 1898. Executive Officer, W. E. Taylor, M. D., Watertown, Ill. Number of beds, 800. Number of patients treated last year, 810. Value of hospital property, $500,000. Supported by State appropriation.

Indiana.

O. S. Runnels' Private Hospital, Indianapolis, Ind. Not incorporated. Opened for patients 1890. Executive Officer, Orange S. Runnels, M. D., 522 North Illinois street, Indianapolis, Ind. Number of beds, 20. Number of patients treated last year, 107. Value of hospital property, $30,000. Supported by pay of patients. Delegate, Orange S. Runnels, M. D.

Banning Orthopedic Institute, Fort Wayne, Ind. Not incorporated. Opened for patients 1896.

Muncie Hospital and Invalid's Home, Homœopathic Department, Muncie, Indiana. Not incorporated. Opened for patients 1891. Executive Officer, W. D. Whitney, M. D., Muncie, Ind. Number of beds, 25. Value of hospital property, $8,000. Supported by fees of patients.

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Epworth Hospital, South Bend, Ind.

Kentucky.

German Methodist Deaconess Home and Hospital, Louisville, Ky. Incorporated 1895. Opened for patients 1895. Executive Officer, Miss Borcherding, Louisville, Ky. Number of beds, 12. Value of hospital property, $18,000. Supported by fees of patients and endowments. Delegate, George S. Coon, M. D. "We are about to build a new hospital."

Pattie A. Clay Infirmary, Richmond, Ky.

Maine.

Trull Hospital, Biddeford, Me. Not incorporated. Opened for patients 1900. Executive Officer, J. Frank Trull, M. D., Biddeford, Me. Number of beds, 25. Number of patients treated last year, 140. Value of hospital property, $40,000. Supported by fees of patients.

Massachusetts.

Cullis' Consumptive's Home, New Dorchester, Mass. Incorporated 1871. Opened for patients 1864.

St. Botholf Hospital, Boston, Mass. Incorporated 1901. Opened for patients 1898.

Talitha Cumi Home of the New England Moral Reform Society, Boston, Mass. Incorporated 1846. Opened for patients 1836. Executive Officer, Julia Morton Plummer, M. D., 160 Huntington avenue, Boston, Mass. Number of beds, 29. Number of patients treated last year (maternity), 66. Value of hospital property, $30,000. Supported by donations. "The ministry of this Home is quite distinct from that of the many other Homes and Refuges in Boston, or even in Massachusetts, having for its sole purpose the providing of a 'door of hope' for those girls who are facing the sadness and shame of unmarried motherhood. It is the aim of this Home to provide such care for both soul and body that these wayward young hearts shall be turned back from their first terrible step in the downward path, and awakened to the hope of a new and better future. It is not the mission of this Home to deal with degraded women who have been promiscuous sinners, but rather with those young girls who have slipped through ignorance or unguarded surroundings, or who have been deceived or seduced through their affections, and are in need of such care for the first time."

Leonard Moore Hospital, Natick, Mass.

Norton Hospital, Homœopathic Department, Taunton, Mass.

Westboro Insane Asylum, Westboro, Mass. Incorporated 1884. Opened for patients 1886. Executive Officer, George S. Adams, M. D., Westboro, Mass. Number of beds, 700. Number of patients treated last year, 955. Value of hospital property, $505,000. Supported by State and Town appropriations, and private contributions. Delegate, George S. Adams, M. D. "The capacity of this hospital will be increased to 770 beds in the course of a month, 100 in another year, as buildings for that number of patients are already planned for."

Michigan.

Union Benevolent Association Hospital, Homœopathic Department, Grand Rapids, Mich. Incorporated 1873. Opened for patients 1886. Executive Officer, Miss Ida Barrett. Number of beds, 50. Number of patients treated last year, 514. It is impossible to ascertain how many of these patients were

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under Homœopathic treatment. Value of hospital property, $68,000. Supported by gifts, paying patients, and a small endowment. "There is no Homœopathic Department in this hospital, but Homœopathic physicians have equal rights and privileges with those of other schools, and are filling positions on the hospital staff. These 'rights and privileges' were not won without some hard fighting and some bitterness of spirit, but now everything seems to be amicably adjusted, and the feeling between the old and new school physicians on the staff is friendly and courteous. Delegate, Maria W. Norris, M. D.

State Asylum, Ionia, Mich. Not incorporated. Opened for patients 1885.

Borgess Hospital, Kalamazoo, Mich. Number of beds, 40. Attending physician, James N. Ayres, M. D., Kalamazoo, Mich. "This hospital is open to physicians of all schools of practice."

Minnesota.

Fergus Falls State Hospital for the Insane, Fergus Falls, Minn. Incorporated 1887. Opened for patients 1890. Executive Officer, George O. Welch, M. D., Fergus Falls, Minn. Number of beds, 1,400. Supported by legislative appropriations. Value of hospital property, $1,000,000. Delegate, George O. Welch, M. D.

Maternity Hospital, Minneapolis, Minn. Incorporated 1887. Opened for patients 1886. Executive Officer, Martha G. Ripley, M. D., 40 South Tenth street, Minneapolis, Minn. Number of beds, 16. Number of patients treated last year, 202. Seven infants died; no deaths among the adults. Value of hospital property, $20,000. Supported by pay of patients and voluntary contributions. "This hospital is strictly Homœopathic in its practice, and the results have been the very best and perfectly satisfactory."

Montana.

Dr. Blackburn's Hospital, Butte, Mont. Not incorporated. Opened for patients 1892. Executive Officer, George E. Blackburn, M. D., Butte, Mont. Number of beds, 12. Number of patients treated last year, 86. Value of hospital property, $10,000. Supported by pay of patients.

New Jersey.

Oak Hill, Montclair, N. J. Not incorporated. Opened for patients 1900. Executive Officer, John T. Greenleaf, M. D., Box 315, Montclair, N. J. Number of beds, 14. Number of persons treated last year, 23. Value of hospital property, $19,000. Supported by pay of patients. Delegate, John T. Greenleaf, M. D.

Dr. Bunn's Private Hospital, East Orange, N. J. Not incorporated. Opened for patients 1899. Executive Officer, Miss Eleanor S. Moseley, Dr. Bunn's Private Hospital, East Orange, N. J. Number of beds, 3, private rooms. Number of patients treated last year, 30. Value of hospital, $20,000. Supported by pay of patients. "This is a small private venture, simply for the purpose of having well-appointed operating room, and private rooms for such patients as do not care to go to a public hospital, or be operated upon at home." Delegate, Frank C. Bunn, M. D.

New York.

Prospect Heights Hospital and Brooklyn Maternity and New York State School for Training Nurses, Brooklyn, N. Y. Incorporated 1871. Opened for

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patients 1871. Executive Officer, Mrs. George F. Demarest, 459 Greene avenue, Brooklyn, N. Y. Number of beds, 45. Number of patients treated last year, 301. Value of hospital property, $65,000. Supported by pay and board of private patients, and voluntary subscriptions. "During the past year one hundred and fifty-eight private patients have been cared for; one hundred and twenty-eight occupied rooms, and thirty-eight the private ward. Eighty-one of these cases were admitted for surgical treatment, forty-one for medical care, and thirty-six for maternity care only. The work of the Training School has gone steadily on through the year, and, through the faithful guidance of the committee and the efficient care of the medical staff and superintendent, training has been given which will be of life-long benefit to the students. The position of the trained nurse is becoming more and more not excelled by any in the walks of life. During the year the class has enjoyed an additional advantage, in a course of instruction in massage, which will furnish them a means in many cases of soothing and relieving the patients in their care."

Brooklyn Nursery and Infant's Hospital, Brooklyn, N. Y. Incorporated 1871. Opened for patients 1871. Executive Officer, Miss Jeannette C. James, Infant's Hospital, 396 Herkimer street, Brooklyn, N. Y. Number of beds, 30. Number of patients treated last year, 300. Value of hospital property, $50,000. Supported by pay of patients and City appropriations. Delegate, Frank E. Risley, M. D., 355 Jefferson avenue, Brooklyn, N. Y.

Lexington Heights Hospital, Buffalo N. Y. Incorporated 1891. Opened for patients 1890. Executive Officer, De Witt G. Wilcox, M. D., 568 Delaware avenue, Buffalo, N. Y. Number of beds, 20. Number of patients treated last year, 267. Value of hospital property, $26,000. Supported by pay of patients. Delegate, De Witt G. Wilcox, M. D. "This is no longer a stock company, but my own private hospital."

Rail Road Men's Hospital, Buffalo, N. Y. Executive Officer, William H. Marcy, M. D., 1148 Main street, Buffalo, N. Y. Number of beds, 15.

Geneva Hygienic Institute, Geneva, N. Y. Not incorporated. Opened for patients 1854. Executive Officer, James C. Knapp, M. D., Geneva, N. Y. Number of beds, 70. Value of hospital propery, $25,000. Supported by board of patients. Delegate, James C. Knapp, M. D.

Gowanda State Homœopathic Hospital, Gowanda, N. Y. Incorporated 1895. Opened for patients 1898. Executive Officer, Daniel H. Arthur, M. D., Gowanda, N. Y. Number of beds, 360. Number of patients treated last year, 421. Value of hospital property, $500,000. Supported by State appropriation, pay of private patients. Delegate, Daniel H. Arthur, M. D. "We are erecting two large buildings for the accommodation of four hundred additional patients, to be completed and ready for occupancy in 1903."

W. C. A. Hospital, Jamestown, N. Y. Executive Officer, Francis D. Ormes, M. D., Jamestown, N. Y. Number of beds, 25.

Middletown State Homœopathic Hospital, Middleton, N. Y. Incorporated 1870. Opened for patients 1874. Executive Officer, Selden H. Talcott, M. D., Middletown, N. Y. Number of beds, 1,287. Number of patients treated last year, 1,425. Value of hospital property, $1,138,000. Supported by State appropriation and pay of private patients. Delegate, Selden H. Talcott, M. D.

New York Ophthalmic Hospital, New York City. Incorporated 1852.

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Opened for patients 1852. Executive Officer, Frank H. Boynton, M. D., 36 West Fiftieth street, New York City. Number of beds, 70. Number of patients treated, 693. Value of hospital property, $100,000. Supported by voluntary contributions. Delegate, Frank H. Boynton, M. D.

Nursery and Children's Hospital, New York City. Executive Officer, William M. Butler, M. D., 507 Clinton avenue, Brooklyn, N. Y. Number of beds, 450.

Glenmary, Owego, N. Y. Incorporated 1897. Opened for patients 1889. Executive Officer, John T. Greenleaf, M. D., Owego, N. Y. Number of beds, 50. Number of patients treated last year, 56. Value of hospital property, $110,000. Supported by pay of patients. Delegate, John T. Greenleaf, M. D.

The Lee Private Hospital, Rochester, N. Y. Not incorporated. Opened for patients 1898. Executive Officer, John M. Lee, M. D., 179 Lake avenue, Rochester, N. Y. Number of beds, 30. Number of patients treated last year, 419. Value of hospital property, $150,000. Supported by fees of patients and invested funds. Delegate, John M. Lee, M. D. "The hospital is in a very flourishing condition, and plans are ready for the erection of a new building, which will nearly double the present capacity."

Yonkers Homœopathic Hospital and Maternity, Yonkers, N. Y. Incorporated 1896. Opened for patients 1896. Executive Officer, Mrs. J. F. Waller, Yonkers, N. Y. Number of beds, 28. Number of patients treated last year, 196. Value of hospital property, $35,000. Supported by City appropriation, voluntary contributions, and pay of patients. Delegates, Russell P. Fay, M. D., R. Oliver Phillips, M. D.

Ohio.

Maternity Hospital, Cleveland, Ohio. Incorporated 1892. Opened for patients 1892. Executive Officer, Mrs. H. A. Everett, Cleveland, Ohio. Number of beds, 7. Number of patients treated last year, 61. The hospital property is rented. Supported by donations, house income, social entertainments, etc. Delegate, Martha E. Stone, M. D.

Chillicothe Emergency Hospital, Homœopathic Department, Chillicothe, Ohio. Incorporated 1898. Opened for patients 1898. Executive Officer, Chillicothe, Ohio. Number of beds, 8. Value of hospital property, $5,000. Supported by private contributions and pay of patients. Delegate, Charles Hoyt, M. D. "This is not in any sense a Homœopathic hospital. Physicians of all schools donate their services to carry on the work, and they are allowed to use any kind of practice which they may see fit."

Dorcas Invalids' Home for Incurables, Cleveland, Ohio. Incorporated 1885. Opened for patients 1865. Executive Officer, Mrs. Gaius J. Jones, 1068 Cass avenue, Cleveland, Ohio. Number of beds, 40. Number of patients treated last year, 51. Value of hospital property, $100,000. Supported by life membership, private donations, and an endowment fund of $25,000. Delegates, Gaius J. Jones, M. D., H. H. Richmond, M. D. "This is a Home for Incurables. They come with all of their belongings, if they have any, and remain as long as they live, under a contract with the Home. Some pay $1,000, some $500, and nearly half of them nothing at all."

Sixth Avenue Private Hospital, Columbus, Ohio. Not incorporated. Opened for patients 1896. Executive Officer, Maurice P. Hunt, M. D., Colum-

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bus, Ohio. Number of beds, 14. Number of patients treated last year, 96. Value of hospital property, $25,000. Supported by pay of patients. Delegate, Maurice P. Hunt, M. D.

Pennsylvania.

The F. Lewis Crozer Home for Incurables, Chester, Pa. Incorporated 1899. Opened for patients 1900. Executive Officer, Miss Katherine Ubil, Upland, Pa. Number of beds, 30. Number of patients treated last year, 23. This is a private institution, supported entirely by Mrs. Lewis Crozer. Delegate, Robert P. Mercer, M. D.

B. F. Betts Private Hospital, Philadelphia, Pa. Not incorporated. Opened for patients 1898. Executive Officer, A. W. Yale, M. D., 1901 Park avenue, Philadelphia, Pa. Number of beds, 10. Value of hospital property, $20,000. Supported by pay of patients. Delegate, B. Frank Betts, M. D.

Bushrod James Eye and Ear Institution, Philadelphia, Pa. Incorporated 1892. Opened for patients 1892. Executive Officer, Emil P. Albrecht, Philadelphia, Pa. Number of beds, 12. Number of patients treated last year, 1,250. The property is rented. Supported by voluntary contributions, and pay of patients. Delegate, Bushrod W. James, M. D.

Logan Square Hospital, Homœopathic Department, Philadelphia, Pa. Number of beds, 20. "This is a private hospital, and the patients are allowed to have the physician of their choice."

Protestant Home for Incurables, Homœopathic Department, Pittsburg, Pa. Incorporated 1883. Opened for patients 1885. Executive Officer, Mrs. A. Long, 236 Shady avenue, Pittsburg, Pa. Number of beds, 60. Number of patients treated last year, 70. Value of hospital property, $100,000. Supported by endowments, admission fees, and voluntary contributions. Delegate, James H. Thompson, M. D., 515 Penn avenue, Pittsburg, Pa.

Rhode Island.

Whitmarsh Private Hospital, Providence, R. I. Not incorporated. Opened for patients 1895. Executive Officer, Henry A. Whitmarsh, M. D., 63 Jackson street, Providence, R. I. Number of beds, 8; all private rooms. Number of cases treated last year, 100. "This hospital is for surgical cases only. Delegate, Henry A. Whitmarsh, M. D.

Texas.

Santa Rosa Infirmary, San Antonio, Texas. This infirmary is under the management of Sisters of Charity of the Incarnate Word. It is located in West Houston street, San Antonio, Texas. Not incorporated. Opened for patients 1869. Number of beds, 200. Number of patients treated last year, 1,200. Supported by pay of patients.

Wisconsin.

Johnson Emergency Hospital, Milwaukee. Incorporated 1895. Opened for patients 1895. Executive Officer, F. B. Golley, M. D., Milwaukee, Wis. Number of beds, 40. Number of patients treated last year, 801. Value of hospital property, $100,000. Supported by City appropriation. Delegate, Joseph Lewis, M. D. "The hospital is open to physicians of both schools of medicine. On the staff, out of thirty-eight members, there are three Homœopathic physicians."

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Washington.

Maria Beard Deaconess Hospital, Spokane, Wash. Number of beds, 17. This hospital is open to physicians of all schools.

HOMŒOPATHIC SANITARIUMS IN THE UNITED STATES.

California.

Homœopathic Sanitarium, San Francisco. Not incorporated. Opened for patients 1896. Executive Officer, William Boericke, M. D., 1812 Washington street, San Francisco, Cal. Number of beds, 40. Number of patients treated last year, 700. Value of sanitarium property, $10,000. Supported by pay of patients. Delegate, James W. Ward, M. D.

Dr. F. H. Bang's Sanitarium for Gynecological and Rectal Surgery, San Jose. Executive Officer, Frederick H. Bang, M. D., San Jose, Cal.

Colorado.

Cooper College Sanitarium, Manitou, Col. Not incorporated. Opened for patients 1895. Executive Officer, Francis M. Cooper, M. D., Manitou, Col. Number of beds "elastic." No record of number of patients treated is kept. Supported by pay of patients. Value of hospital property, $30,000.

Connecticut.

Elmcroft, Enfield, Conn. Not incorporated. Opened for patients 1890. Executive Officer, Edwin Smith Vail, M. D., Enfield, Conn. Number of beds, 25. Number of patients treated last year, 78. Value of hospital property, $35,000. Supported by pay of patients. "This is a private sanitarium for the treatment of nervous and mental diseases only."

Crest View Sanitarium, Greenwich, Conn. Not incorporated. Opened for patients 1894. Executive Officer, Henry M. Hitchcock, M. D., Greenwich, Conn. Number of beds, 30. Number of patients treated last year, 50. Value of hospital property, $50,000. Supported by pay of patients.

E. L. Styles' Sanitarium, New Britain, Conn. Not incorporated. Opened for patients 1896. Executive Officer, E. L. Styles, M. D., New Britain, Conn. Number of beds, 20. Number of patients treated last year, 101. Value of hospital property, $50,000. Delegate, E. L. Styles, M. D.

Home Rest, South Norwalk, Conn. Incorporated 1894. Opened for patients 1894. Number of beds, 9. Executive Officer, Emily V. D. Pardee, M. D., South Norwalk, Conn. Value of sanitarium property, $30,000. Supported by pay of patients. Delegate, Emily V. D. Pardee, M. D. "This is exclusively a Homœopathic sanitarium, in the true sense of the term."

Dr. Givens' Sanitarium, Stamford, Conn. Not incorporated. Opened for patients 1891. Executive Officer, Amos J. Givens, M. D., Stamford, Conn. Number of beds, 175. Value of hospital property, $100,000. Supported by pay of patients. Delegate, Amos J. Givens, M. D. "This sanitarium is arranged on the cottage plan."

Illinois.

Bloomington Homœopathic Sanitarium, Bloomington, Ill. Not incorporated. Opened for patients 1894. Executive Officer, George B. Kelso, M. D., Bloomington, Ill. Number of beds, 25. Number of patients treated last year, 150. Value of hospital property, $25,000. Supported by pay of patients.

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"This institution is a private sanitarium and surgical hospital for surgery, obstetrics and chronic diseases; no acute or contagious diseases taken."

Skiles Orificial Sanitarium, Chicago, Ill. Incorporated 1898. Opened for patients 1894. Executive Officer, Hugh P. Skiles, M. D., 963 West Monroe street, Chicago, Ill.

West Chicago Sanitarium, Chicago, Ill. Incorporated 1892. Opened for patients 1892. Executive Officer, Mark M. Thompson, M. D., 805 Monroe street, Chicago, Ill. Number of beds, 10. Number of patients treated last year, 104. Value of hospital property, $50,000. Supported by pay of patients. Delegate, Mark M. Thompson, M. D. "This is a strictly Homœopathic institution for the treatment of all kinds of surgical and medical cases."

Garfield Park Sanitarium, Chicago, Ill. Executive Officer, Frank Brannin, M. D., 961 West Monroe street, Chicago, Ill. Number of beds, 50.

Rogers Sanitarium, Chicago, Ill. Executive Officer, L. D. Rogers, M. D., 441 Dearborn avenue, Chicago, Ill.

Enos' Sanitarium, Alton, Ill. Executive Officer, William H. Enos, M. D., Alton, Ill. Number of beds, 12.

Indiana.

Dr. B. F. Bye's Sanitarium, Indianapolis, Ind. Not incorporated. Opened for patients 1896. Number of beds, 30. Number of patients treated last year, 609. Value of hospital property, $10,000. Supported by pay of patients.

Indiana Mineral Springs Sanitarium, Homœopathic Department, Attica, Ind. Executive Officer, E. M. McAffee, M. D., Attica, Ind. "This sanitarium is open to both schools of medicine."

Oak Park Sanitarium, Elkhart, Ind. Not incorporated. Opened for patients 1884. Executive Officer, F. A. Benham, M. D., Elkhart, Ind. Number of beds, 5. Value of hospital property, $10,000. Supported by pay of patients. "This is a private institution for the reception and treatment of old chronic cases of disease which cannot be taken care of at home."

Iowa.

Iowa State Sanitarium, Marshalltown, Iowa. Incorporated 1895. Opened for patients 1895. Executive Officer, I. Wickliff Bouldin, M. D., Marshalltown, Iowa. "This sanitarium is not yet equipped for the care of private patients in separate rooms. Patients board and room outside of the sanitarium."

The Drake Sanitarium, Des Moines, Iowa. Incorporated 1889. Opened for patients 1889. Executive Officer, Joseph H. Drake, M. D., 826 W. Fourth street, Des Moines, Iowa. Number of beds, 20. Number of patients treated last year, 220. Value of hospital property, $8,000. Supported by pay of patients. Delegate, Joseph H. Drake, M. D.

Maryland.

Baltimore Homœopahic Sanitarium, Baltimore, Md. Not incorporated. Opened for patients 1893. Executive Officer, Flora A. Brewster, M. D., 1221 Madison avenue, Baltimore, Md. Number of beds, 5. Number of patients treated last year, 48. Value of hospital property, $25,000. Supported by pay of patients. Delegate, Flora A. Brewster, M. D.

Barnard's Sanitarium, Baltimore, Md. Incorporated 1900. Opened for

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patients 1900. Executive Officer, James S. Barnard, M. D., Baltimore, Md. Number of beds, 35. Number of patients treated last year, 125. Value of hospital property, $60,000. Supported by fees of patients. Delegate, James S. Barnard, M. D.

Dr. E. Z. Cole's Sanitarium, Baltimore, Md. Not incorporated. Opened for patients 1896. Executive Officer, Edward Z. Cole, M. D., 1534 Mount Royal avenue, Baltimore, Md. Number of beds, 10. Number of patients treated last year, 96. Value of hospital property, $15,000. Supported by pay of patients. "This institution is not large, but it contains the advantages of the modern, up-to-date hospital, with the comforts of a very pleasant home,

Carroll Springs Sanitarium, Forest Glen, Md. Not incorporated. Opened for patients 1887. Executive Officer, George H. Wright, M. D., Forest Glen, Md. Number of beds, 40. Number of patients treated last year, 130. Value of hospital property, $50,000. Supported by pay of patients.

Massachusetts.

The Walter Baker Sanitarium, Boston, Mass. Incorporated 1892. Opened for patients 1892. Executive Officer, C. J. Douglass, M. D., 524 Warren street, Boston, Mass. Number of beds, 23. Number of patients treated last year, 124. Value of hospital property, $40,000. Supported by pay of patients. "This institution is for the treatment of alcoholism and other drug addictions, and nervous diseases. It is conducted on modern and scientific principles. It is in no sense a 'gold cure.' We never allow the use of straight jackets or cells, neither do we practice the sudden and instantaneous withdrawal of alcohol or other drugs to which the patient has been in the pracice of using."

Framingham Nervine, Framingham, Mass. Not incorporated. Opened for patients 1896. Executive Officer, Ellen L. Keith, M. D., Framingham, Mass. Number of beds, 24. Number of patients treated last year, 36. Value of hospital property, $24,000. Supported by pay of patients,. Delegate, Ellen L. Keith, M. D.

Woodside Cottage, Framingham, Mass. Not incorporated. Opened for patients 1900. Executive Officer, Frank W. Patch, M. D., Framingham, Mass. Number of beds, 6. Number of patients treated last year, 25. Value of hospital property, $8,000. Supported by pay of patients. "This institution is designed for the care and treatment of chronic diseases, especially those of nervous origin."

Newton Sanitorium, Newton, Mass. Not incorporated. Opened for patients 1892. Executive Officer, E. Emmons Paine, M. D., West Newton, Mass. The number of beds is variable according to the needs. Supported by the pay of patients. Delegate, N. Emmons Paine, M. D. "This institution is composed of private residences in the neighborhood, where certain of our patients are recéived, the number varying as the needs may require."

Newton Nervine, West Newton, Mass. Not incorporated. Opened for patients 1892. Executive Officer, N. Emmons Paine, M. D., West Newton, Mass. Number of beds, 18, at the present time (June 1st), but will be 30 by August 1st. Number of patients treated last year, 41. Value of hospital property, $57,000. Supported by pay of patients. Delegate, N. Emmons Paine, M. D.

Massachusetts State Sanitarium, Homœopathic Department, Rutland, Mass.

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Incorporated 1895. Opened for patients 1898. Executive Officer, Herbert C. Clapp, M. D., Boston, Mass. Number of beds, 76. Number of patients treated last year, 245. These figures refer to those under Homœopathic care and treatment. Value of hospital property, $325,000. Supported by State appropriation, and pay of patients. "With the opening of the new building the number of beds in the Homœopathic Department will be increased to 100 or 125."

Locust Grove Sanitarium, Sandwich, Mass. Incorporated 1895. Opened for patients 1895. Executive Officer, Miss Alice R. Coope, Sandwich, Mass. Number of beds, 4. Value of hospital property, $3,000. Supported by pay of patients. Delegate, G. E. White, M. D. "Owing to accident and illness in the family of the superintendent, all applications for the past year have been refused."

Barcall's Sanitarium, Springfield, Mass. Not incorporated. Opened for patients 1890. Number of beds, 12.

Wellesley Nervine, Wellesley, Mass. Incorporated 1897. Opened for patients 1897. Executive Officer, Edward H. Wiswall, M. D., Wellesley, Mass. Number of beds, 15. Number of patients treated last year, 29. Value of hospital property, $27,500. Supported by pay of patients. "Special cottages have been provided for the accommodation of those patients who require isolation in the treatment of their mental disease."

The Pines, Worcester, Mass. Not incorporated. Opened for patients 1900. Executive Officer, H. A. Gibbs, M. D., Worcester, Mass. Number of beds, 12. Value of hospital property, $20,000. Supported by pay of patients.

Michigan.

Reed City Sanitarium and Private Hospital, Reed City, Mich. Not incorporated. Opened for patients 1895. Executive Officer, Andrew B. Spinney, M. D., Reed City, Mich. Number of beds, 60. Number of patients treated last year, 205. Value of hospital property, $25,000. Supported by pay of patients. Delegate, Andrew B. Spinney, M. D.

Minnesota.

Lawrence Sanitarium, Minneapolis, Minn. Not incorporated. Opened for patients 1892. Executive Officer, William D. Lawrence, M. D., 1000 First avenue, South, Minneapolis, Minn. Number of beds, 20. Number of patients treated last year, 152. Value of hospital property, $75,000. Supported by pay of patients. Delegate, William D. Lawrence, M. D.

Missouri.

Dr. Coe's Sanitarium, Kansas City, Mo. Executive Officer, Charles M. Coe, M. D., Eleventh and Walnut streets, Kansas City, Mo. Number of beds, 50. "This is a private sanitarium."

Montana.

Kellogg Sanitarium, Helena, Mont. Incorporated 1894. Opened for patients 1894. Executive Officer, Edwin S. Kellogg, M. D., Helena, Mont. Number of beds, 17. Number of patients treated last year, 489. Value of hospital property, $15,000. Supported by pay of patients.

Nebraska.

Dr. Benjamin F. Bailey Sanitarium, Lincoln, Neb. Incorporated 1901. Opened for patients 1901. Executive Officer, Benjamin F. Bailey, M. D., Lin-

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coln, Neb. Number of beds, 40. Number of patients treated last year, 80. Value of hospital property, $55,000. Supported by pay of patients. Delegate, Benjamin F. Bailey, M. D.

New Mexico.

Galen Hall, Atlantic City, N. J. Incorporated 1900. Opened for patients 1895. Executive Officer, W. Kneisel, Atlantic City, N. J. Number of beds, 200. Number of patients treated last year, between 2,000 and 3,000. Value of hospital property, $200,000. Supported by pay of patients. Delegate, John R. Fleming, M. D. "Galen Hall is not surpassed by any institution of like character in the country. Buildings, furnishings, baths, and all treatment rooms are as good as money and judgment can make them."

Lakewood Sanitorium, Lakewood, N. J. Not incorporated. Opened for patients 1885. Executive Officer, H. H. Cate, M. D., Lakewood, N. J. Number of beds, 20.

Brookside Retreat, Plainfield, N. J. Incorporated 1891. Opened for patients 1889. Executive Officer, Justus H. Cooley, M. D., 122 Westervelt avenue, Plainfield, N. J. Number of beds, 25. Value of hospital property, $50,000. Supported by pay of patients.

Plainfield Sanitarium, Plainfield, N. J. Not incorporated. Opened for patients 1879. Executive Officer, Justus H. Cooley, M. D., 122 Westervelt Avenue, Plainfield, N. J. Number of beds, 22. Value of hospital property, $20,000. Supported by pay of patients.

New York.

Muncie Seaside Sanitarium, Babylon, Long Island, N. Y. Not incorporated. Opened for patients 1895. Executive Officer, L. C. Campbell, Babylon, N. Y. Number of beds, 100. Number of patients treated last year, 75. Value of hospital property, $30,000. Supported by pay of patients. Delegate, E. H. Muncie, M. D.

Bethesda Sanitarium, Brooklyn, N. Y. Incorporated 1894. Opened for patients 1894. Executive Officer, Mrs. Howard M. Smith, Brooklyn, N. Y. Number of beds, 25. Number of patients treated last year, 40. Value of hospital property, $25,000. Supported by private subscriptions. Delegate, Harry G. Preston, M. D.

Muncie Sanitarium, Brooklyn, N. Y. Not incorporated. Opened for patients 1893. Executive Officer, L. M. Campbell, Brooklyn, N. Y. Number of beds, 18. Number of patients treated last year, 240. Value of hospital property, $60,000. Supported by pay of patients. Delegate, Libbie H. Muncie, M, D.

Willis Sanitarium, Brooklyn, N. Y. Not incorporated. Opened for patients 1895. Executive Officer, Miss E. E. Ward, 1453 Pacific Street, Brooklyn, N. Y. Number of beds, 30. Number of patients treated last year, 40. Supported by pay patients.

Highland Pines Sanitarium, Corning, N. Y. Not incorporated. Opened for patients 1891. Executive Officer, Mark S. Purdy, M. D., Corning, N. Y. Number of beds, 15. Value of hospital property, $8,000. Supported by pay of patients. Delegate, Mark S. Purdy, M. D. "This institution is devoted to the treatment of chronic diseases and the morphine and opium habits. We also do considerable surgical work."

Interpines Sanitarium, Goshen. Incorporated 1890. Opened for patients

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1890. Executive Officer, Frederick W. Seward, M. D., Goshen, N. Y. Number of beds, 40. Number of patients treated last year, 90. Value of hospital property, $55,000. Supported by pay patients. Delegate, Frederick W. Seward, M. D. "Interpines is a model private Sanitarium devoted to the care and treatment of diseases of the nervous system under strictly Homœopathic regime."

Liberty Homœopathic Sanitarium for Tuberculosis, Liberty. Not incorporated. Opened for patients 1898. Executive Officer, Howard Percy Deady, M. D., Liberty, N. Y. Number of beds, 30. Value of hospital property, $50,000. Supported by pay of patients. "This is the only Homœopathic sanitarium devoted to the climatic treatment of consumptives in this country."

Rochester Sanitarium, Rochester. Not incorporated. Opened for patients 1894. Executive Officer, George W. Wild, M. D., 20 North Clinton Street, Rochester, N. Y. Number of beds, 10. Value of hospital property, $2,000. Supported by pay of patients. Delegate, George W. Wild, M. D.

Ayres' Homœopathic Sanitarium, Saratoga Springs, N. Y. Not incorporated. Opened for patients, 1888. Executive Officer, Emma F. M. Ayres, M. D., 69 Caroline street, Saratoga Springs, N. Y. Number of beds, 8. Number of patients treated last year, 156. Value of hospital property, $12,000. Supported by fees of patients.

Ohio.

Dr. C. E. Sawyer Sanitarium, Marion. Incorporated 1895. Opened for patients 1895. Executive Officer, Charles E. Sawyer, M. D., Marion, Ohio. Number of beds, 82. Number of patients treated last year, 300. Value of hospital property, $115,000. Supported by pay of patients. Delegate, Charles E. Sawyer, M. D.

Worthington Sanitarium, Worthington, Ohio. Executive Officer, Sylvester W. Beall, M. D., Worthington, Ohio. Number of beds, 25.

Pennsylvania.

Easton Sanitarium, Easton, Pa. Incorporated 1894. Opened for patients 1894.

The Walter Sanitarium, Walter Park, Pa. Not incorporated. Opened for patients 1877. Executive Officer, Robert Walter, M. D., Walter Park, Pa. Number of beds, 150. Number of patients treated last year, 507. Value of hospital property, $200,000. Supported by pay of patients. Delegate, Robert Walter, M. D.

Vermont.

The Sparhawk Sanitarium, Burlington, Vt. Not incorporated. Opened for patients 1887. Executive Officer, George E. E. Sparhawk, M. D., Burlington, Vt. Number of beds, 30. Number of patients treated last year, 108. Value of hospital property, $40,000. Supported by fees of patients. "We are now making an addition of twelve rooms, hoping thus to accommodate all applicants."

Wisconsin.

Albany Sanitarium, Albany, Wis. Not incorporated. Opened for patients 1896. Executive Officer, Lena M. Whitcomb, M. D., Albany, Wis. Number of beds, 9. Number of patients treated last year, 40. Value of hospital property, $12,000. Supported by pay of patients. Delegate, Lena M. Whitcomb, M. D.

Pennoyer Sanitarium, Kenosha, Wis. Incorporated 1889. Opened for patients 1890. Executive Officer, Nelson A. Pennoyer, M. D., Kenosha, Wis.

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Number of beds, 100. Number of patients treated last year, 643. Value of hospital property, $150,000. Supported by pay of patients. Delegate, Nelson A. Pennoyer, M. D.

INSTITUTIONS UNDER HOMŒOPATHIC TREATMENT.

California.

Masonic Home, De Coto, Cal. Incorporated 1892. Opened for inmates 1899. Executive Officer, J. R. Aiken, M. D., De Coto, Cal. Number of beds, 156. Number of patients treated last year, 105. Value of institution property, $200,000. Supported by per capita tax on all Masons in the state.

Protestant Orphan Asylum, Sacramento, Cal. Incorporated 1887. Opened for inmates 1867. Executive Officer, Mrs. Jennie Cady Morgan, Sacramento, Cal. Number of beds, 155. Number of patients treated last year, 176. Value of institution property, $50,000. Supported by state appropriation and voluntary contribution. "This institution has been wholly under Homœopathic treatment for over eleven years, during which time there has been only three deaths, and we had an epidemic of thirteen cases of diphtheria, eighty-nine cases of measles, at one time, besides almost everything else that children could have." Delegate, Pliny Watts, M. D.

Sacramento Foundling Home, Sacramento, Cal. Incorporated 1890. Opened for inmates 1895. Executive Officer, Mrs. William Rider, 1629 F Street, Sacramento, Cal. Number of beds, 74. Number of patients treated last year, 150. Value of institution property, $8,000. Supported by State appropriation and charitable contributions. "All deaths, twelve, were infants under two months old, and in most cases with specific infection, possibly syphilis." Delegate, James T. Martin, M. D.

Armitage Home, San Mateo, Cal. Executive Officer, L. A. Wadham, 530 California Street, San Francisco, Cal. Number of beds, 200. Supported by church aid, and state appropriation. Delegate, C. D. Potter, M. D., 406 Sutter street, San Francisco, Cal.

Maria Kip Orphanage, San Francisco, Cal. Incorporated 1890. Opened for inmates 1890. Executive Officer, Miss Carrie Gwin, 2524 Washington street, San Francisco, Cal. Number of beds, 125. Value of institution property, $30,000. Supported by church aid, private contributions and state appropriation. Delegate, Sidney Worth, M. D., 606 Sutter street, San Francisco, Cal.

San Francisco Nursery for Homeless Children, San Francisco, Cal. Incorporated 1892. Opened for inmates 1878. Executive Officer, Mrs. J. Bertz, 1326 Hayes Street, San Francisco, Cal. Number of beds, 80. Number of patients treated last year, 708. Value of institution property, $12,000. Supported by charity, and state aid. Delegate, Guy S. Manning, M. D., 135 Geary street, San Francisco, Cal. "During the past year we have had epidemics of measles; measles in every form, slight, severe, complicated, serious; 1901 closed with them; 1902 began with them; twice when we had declared the quarantine ended, a new installment would break out, till nearly every child in the Home counted himself a "past master" in the measles. The lung complications were especially severe, and bronchitis in several cases endangered the lives of those already constitutionally weak, and several might be named in whom the faint spark of life had to be carefully watched for fear it would give a last flicker and die out. Whooping cough was another bad attendant of the

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measles and increased the seriousness of the cases, and also quite generally laid its hands upon the "baby room." Outside of this period, our sick room has been practically empty; other ailments of children have as usual made their appearance, but a few days in their own bed in the general wards was all that was necessary. The tiny infant whom we had with us at the last annual meeting, having been received when less than twenty-four hours old, and which we saw through the measles and whooping cough, after staying with us for about six months, finally succumbed to meningitis, making the first death in over four years."

Colorado.

Brightside School for Boys, Brightside, Col. Executive Officer, Ralph Field, Brightside, Col.

Belle Lenox Nursery, Denver, Col. Number of beds, 50. "This is not a hospital, but a boarding school for girls, of which Dr. J. P. Willard has charge." Number of beds, 45. Number of patients treated last year, 75.

The Haven Training School for Girls, Denver, Col. "This is not a hospital, but a school for young ladies, of which Dr. J. P. Willard has the charge." Number of beds, 55. Number of patients treated last year, 60.

Denver Orphan's Home, Denver, Col. Incorporated 1880. Opened for inmates 1881. Executive Officer, Mrs. Olive C. Kassler, Denver, Colo. Number of beds, 300. Supported by Associated Charities. Delegate, Samuel F. Shannon, M. D. "The Home has been recently improved by the erection of a new building, which can accommodate three hundred children, and is the finest in the state at the present time. There has been but one death in the institution in two years."

Illinois.

Chicago Nursery and Half Orphan Asylum, Chicago, Ill. Incorporated 1865. Opened for patients 1865.

Chicago Foundling Home for Mothers and Infants, Chicago, Illinois. Incorporated 1872. Opened for inmates 1871. Executive Officer, Mrs. F. E. Shipman, 120 South Wood Street, Chicago, Ill. Number of beds, 104. Number of patients treated last year, 423. Value of institution property, $25,000. Supported by a few investments and voluntary contributions. Delegate, Charles A. Weirick, M. D. "The cause of many cases of mortality was an unfortunate inheritance physically. Most of the babies are "bottle babies," and yet, when they have been sick, have made excellent recoveries, even under very serious drawbacks."

Illinois Masonic Orphan Home, Chicago, Ill. Incorporated 1885. Opened for inmates 1885. Executive Officer, E. S. Gurney, 878 Monroe Street, Chicago, Ill. Number of beds, 100. Delegate, E. C. Sweet, M. D., 70 State street, Chicago, Ill. Value of institution property, $80,000. Supported by contributions of Masons in the State of Illinois.

Indiana.

Old Ladies' Home, New Albany, Ind. Executive Officer, Mrs. Rebecca Culbertson, Louisville, Ky. Number of beds, 14. Value of institution property, $19,000. Supported by an endowment fund. Delegate, G. Oscar Erni, M. D., New Albany, Ind.

Iowa.

Iowa School for the Deaf, Council Bluffs, Iowa. Incorporated 1875. Opened for inmates 1878. Executive Officer, Harvey W. Rothert, Council

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Bluffs, Iowa. Number of beds, 350. Number of patients treated last year, 145. Value of institution property, $30,000. Supported by State Appropriation. Delegate, Alfred P. Hanchett, M. D.

Home for Aged and Infirm, Des Moines, Iowa. Incorporated 1896. Opened for inmates 1896. Executive Officer, Mrs. Dickenson, Fourth and Centre streets, Des Moines, Iowa. Number of beds, 35. Number of patients treated last year, 10. Value of institution property, $80,000. Supported by donations. Delegate, George Royal, M. D.

Kansas.

Atchison Orphan's Home, Atchison, Kan.

Massachusetts.

Ayer Home for Young Women and Children, Lowell, Mass. Incorporated 1875. Opened for inmates 1875. Executive Officer, Mrs. A. G. Rouviere, 159 Pawtucket street, Lowell, Mass. Number of beds, 50. Number of patients treated last year, 40. Value of institution property, $40,000. Supported by endowments and donations. Delegate, G. Forrest Martin, M. D.

Newton City and Middlesex County Prison, Newton, Mass. Incorporated 1815. Opened for inmates 1816. Executive Officer, John F. Fairbairn, Newton, Mass. Number of beds, 510. Number of patients treated last year, 4009. Value of institution property, $592,000. Supported by County and City tax. Delegate, Edward R. Utley, M. D.

Michigan.

Thompson Home for Old Ladies, Homœopathic Department, Detroit, Mich. Attending physician, Christopher C. Miller, M. D., 31 Winder street, Detroit, Mich. "This institution is open to every school of practice."

Michigan State Prison, Jackson, Mich. Incorporated 1839. Opened for inmates 1839. Executive Officer, William Chamberlain, Jackson, Mich. Number of beds, 25. Number of patients treated last year, 136. Value of institution property, $300,000. Supported by state appropriation. Delegate, William A. Gibson, M. D.

Michigan Home for Feeble-minded and Epileptics. Lapeer, Mich. Not incorporated. Opened for inmates 1895. Executive Officer, William A. Poglase, M. D., Lapeer, Mich. Number of beds, 500. Number of patients treated last year, 403. Value of institution property, $300,000. Supported by state appropriation. Delegate William A. Poglase, M. D. Cases sent to this institution are all mentally defective, and with scarcely an exception, epileptics."

Missouri.

Baptist Orphans' Home, St. Louis, Mo. Incorporated 1883. Opened for inmates 1886. Executive Officer, Mrs. A. H. Eilers, St. Louis, Mo. Number of beds, 55. Number of patients treated last year, unknown; no record kept. Value of institution property, $30,000. Supported by small endowment and voluntary contributions. Delegate, Carl J. Luyties, M. D.

Girl's Industrial Home, St. Louis, Mo. Incorporated 1854. Opened for Inmates, 1854.

New Mexico.

Home for the Homeless, Homœopathic Department, Jersey City, N. J. Incorporated 1881. Opened for inmates 1881. Executive Officer, Joseph A. Dean,

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37 Montgomery Street, Jersey City, N. J. Number of beds, 70. Value of institution property, $15,000. Supported by voluntary contributions.

Home for Aged Women, Newark, N. J. "This Home is nonsectarian, either in religion or in medicine. Dr. E. D. G. Conkling attended ten patients during the last year. Allopathic physicians also attend many of the inmates. Each one has the choice of her physician."

Children's Home, Plainfield, N. J. Incorporated 1877. Opened for inmates 1877. Executive Officer, Miss Lucy H. Everett, Plainfield, N. J. Number of beds, 30. Value of institution property, $15,000. Supported by voluntary contributions, and partial board of children, in many cases. Delegate, Edward Rushmore, M. D. "This is not a hospital, but an Orphan's Home, where children are cared for until they are old enough to be placed in private families.

New York.

Asylum for the Relief of Half-Orphan and Destitute Children, New York, N. Y. Incorporated 1835. Opened for inmates 1835. Executive Officer, Mrs. John L. Sutherland, 17 West Thirty-seventh street, New York City. Number of beds, 200. Number of patients treated last year, 86. Delegate, Alvin Woodward, M. D. "With the advent of winter came pneumonia as an unwelcome visitor to the little ones, seven of whom suffered from this disease, as well as the nurse who had rendered such faithful service to the children during so many years. The complete recovery of all gave full reward for our labor and extra anxiety. In January scarlatina developed in the Nursery and extended to the larger children. This necessitated the quarantining of the whole Home till the late spring and deprived the children of the privilege of attendance at church, which they prize so highly. We have lost none of our number by death during the year."

Baptist Home for the Aged. Homœopathic Department, New York City. Incorporated 1869. Opened for inmates 1869. Executive Officer, Mrs. Richard Collins, 22 East Seventy-fourth street, New York City. Number of beds, 100. Number of patients treated last year, 81. Value of institution property, $200,000. The lot is owned by the City of New York. Supported by voluntary contributions from the Baptist Church in the Borough of Manhattan, New York City. Delegate, H. Everett Russell, M. D.

Chapin Home for the Aged and Infirm, Homœopathic Department, New York City. Executive Officer, Mrs. E. T. Sherman, 114 West Forty-fourth street, New York City. Number of beds, 65. Value of institution property, $150,000. Supported by voluntary contributions and a small endowment fund. "This Home is the only one in the City of New York which does not require some religious or city residence test in order to enter it."

Home for the Friendless, New York City. Incorporated 1839. Opened for inmates 1840. Executive Officer, Mrs. Frank S. Evans, 105 East Twenty-second Street, New York City.

Hospital of the Five Points House of Industry, New York City. Incorporated 1854. Opened for inmates 1860. Executive Officer, William F. Barnard, 155 Worth street, New York City. Number of beds, 70. Number of patients treated last year, including "Out Door" department, 1,878. Value of institution property, $350,000. Supported by city appropriation and private subscriptions.

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Lana-ac-Tela Home, New York City. Executive Officer, Mrs. John E. L. Davis, 743 Madison Avenue, New York City.

New York Christian Home for Intemperate Men, Mount Vernon, N. Y. Incorporated 1875. Opened for patients 1875. Executive Officer, Mrs. William E. Dodge, New York City.

Ohio.

Home of the Friendless and Foundlings, Cincinnati, Ohio. Incorporated 1860. Opened for inmates 1860. Executive Officer, Mrs. William C. Biler, 2626 Euclid Avenue, Cincinnati, Ohio. Number of beds, 51 Adults, 41 Infants. Number of patients treated last year, 331. Supported by endowment fund and voluntary contributions. Delegate, Thomas M. Stewart, M. D.

Cleveland Bethany Home for Children, Cleveland, Ohio. Incorporated 1895. Opened for inmates 1894. Executive Officer, Mrs. M. C. Worthington, 485 Euclid Avenue, Cleveland, Ohio. Number of beds, 24. Number of patients treated last year, 30. Value of institution property, $10,000. Supported by voluntary contributions. Delegate, Harlan Pomeroy, M. D.

Eliza Jennings Home, Cleveland, Ohio. Incorporated 1869. Opened for inmates 1868. Executive Officer, Mrs. Presley, 1031 East Madison avenue, Cleveland, Ohio. Number of beds, 20. Number of patients treated last year, 26. Value of institution property, $30,000. Supported by an endowment fund of $25,000, and voluntary donations. Delegate, William E. Trego, M. D. "This is the Home for Incurables, and is a part of the Y. M. C. A. work."

Oregon.

Children's Home, Portland, Oregon. Incorporated 1870. Opened for inmates 1897. Executive Officer, Henry C. Jefferds, M. D., 67 Dakum Building, Portland, Oregon. Number of beds, 100. Value of institution property, $50,000. Supported by endowment fund, state appropriation, and voluntary contributions. Delegate, Henry C. Jefferds, M. D.

Pennsylvania.

Boys' Boarding House, Allegheny, Pa. Incorporated 1886. Opened for inmates 1870. We have been unable to obtain any report whatever from this institution this year.

Convent of Benedictine Sisters, Erie, Pa. Not incorporated. Opened for inmates 1865. Executive Officer, Mother Superior, 322 East Minot street, Erie, Pa. Number of beds, 10. Number of patients treated last year, 121. Supported by voluntary contributions. Delegate, Edward Cranch, M. D.

Rhode Island.

Sophia Little Home, Homœopathic Department, Edgwood, R. I. Incorporated 1882. Opened for inmates 1882. Executive Officer, Miss Colwell, Norwood Avenue, Edgewood, R. I. Number of beds, 32. Value of institution property, $50,000. Supported by donations and state appropriations. Delegate, Richard H. Eddy, M. D. "Six physicians of each school of medicine serve one month each in a year."

St. Elizabeth's Home, Providence, R. I. Not incorporated. Opened for inmates 1883. Executive Officer, Miss E. C. Fales, St. Elizabeth's Home, Providence, R. I. Number of beds, 50. Value of institution property, $50,000. Supported by gifts, endowment fund, and entrance fee of inmates. Delegate, Edward B. Knight, M. D. "There is an Allopathic as well as a

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Homœopathic medical staff attached to this Institution, and both are working harmoniously together."

Children's Friend Society (Tobey Street Home), Providence, R. I. Incorporated 1836. Opened for inmates 1835. Executive Officer, Mrs. Mary A. Talbot, 55 Congdon street, Providence, R. I. Number of beds (in the hospital), 25. Number of patients treated last year, 43. Value of institution property, $65,000. Supported by endowment fund and private subscriptions. Delegate, Henry M. Sanger, M. D.

Providence Rescue Home and Mission, Providence, R. I. Incorporated 1896. Opened for inmates 1895. Executive Officer, Miss M. H. Dennehy, Providence, R. I. Number of beds, 16. Value of institution property, $15,000. Supported by private charity. Delegate, Henry A. Whitmarsh, M. D. "This institution is for young women and girls who have not yet become hardened, a majority of whom afterward become mothers and are provided with situations where they can have their children with them. The results of these cases are most satisfactory."

Wisconsin.

House of Mercy, Homœopathic Department, Milwaukee, Wis. Incorporated 1888. Opened 1888. Executive Officer, Mrs. Julia Kurtz, 483 Thirty-fifth street, Milwaukee, Wis. Number of Beds, 50. Value of institution property, $25,000. Supported by voluntary contributions. Delegate, S. D. Johnson, M. D. "Six old school physicians attend six months in each year, and six Homœopathic physicians attend the other six months in the year."

Milwaukee Orphan Asylum, Homœopathic Department, Milwaukee, Wis. Incorporated 1849. Opened for inmates 1850. Executive Officer, Mrs. Ferdinand Meinecke, Jr., Milwaukee, Wis. Number of beds, 125. Number of patients treated last year, 43. Value of institution property, $100,000. Supported by public philanthropy. Delegate, Walter W. Irving, M. D. "Dr. Irving is the only Homœopathic physician in attendance at the asylum, and these patients which he treated were in the Eye, Ear, Nose and Throat Department."

HOMŒOPATHIC DISPENSARIES IN THE UNITED STATES.

Arkansas.

Little Rock Homœopathic Dispensary, Little Rock, Ark. Attending physician, George V. Thomas, M. D., 516 Main street, Little Rock, Ark.

California.

Pacific Homœopathic Polyclinic, San Francisco, Cal. Not incorporated. Opened for patients 1889. Executive Officer, Florence N. Ward, M. D., 606 Sutter street, San Francisco, Cal. Number of patients treated last year, 10,309. Number of prescriptions given last year, 11,731. Delegate, Florence N. Ward, M. D.

District of Columbia.

National Homœopathic Hospital Association Dispensary, Washington, D. C. Not incorporated. Opened for patients 1900.

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Illinois.

Chicago Homœopathic Free Dispensary, Chicago, Ill. Incorporated 1876. Opened for patients 1876. Executive Officer, Walter E. Fruitt, M. D., 4647 Indiana Avenue, Chicago, Ill. Number of patients treated last year, 4,023. Number of prescriptions given last year, 6,017. Number of outside visits made last year, 312. Cost of conducting the dispensary last year, $192.00. Delegate, Edwin H. Pratt, M. D.

Dunham College Dispensary, Chicago, Ill. Incorporated 1895. Opened for patients 1895. Executive Officer, Guernsey P. Waring, M. D., 92 State Street, Chicago, Ill. Number of patients treated last year, 1,107. Number of prescriptions last year, 2,178. Number of outside visits made last year, 421. Cost of conducting the dispensary last year $319.00. Delegate, Guernsey P. Waring, M. D.

Hahnemann College Free Dispensary, Chicago, Ill. Incorporated 1855. Opened for patients 1855. Executive Officer, J. C. Burt, 2811 Cottage Grove avenue, Chicago, Ill. Number of patients treated last year, 14,963. Number of prescriptions given last year, 39,763. Number of outside visits made last year, 2,412. Cost of conducting dispensary last year, $3,263.83. Delegate, George F. Shears, M. D.

Kirk Medical Dispensary, Chicago, Ill. Executive Officer, Henry H. Depew, M. D., 112 Clark street, Chicago, Ill. "This is a private dispensary, and not a free dispensary."

Indiana.

Richmond Homœopathic Free Dispensary, Richmond, Ind. Not incorporated. Incorporated 1899. Opened for patients 1882. Executive officer, F. H. Dunham, M. D., 143 School street, Richmond, Ind. "We still have an election of officers each year, and our annual meeting, but have not had the dispensary open since our last report. The annual meeting and banquet occurs June 2, 1902.

Iowa.

City Free Dispensary of Council Bluffs, Iowa. Not incorporated. Opened for patients 1882. Executive officer, Mabel C. Becroft, 217 Fourth street, Council Bluffs, Iowa. Number of patients treated last year, 93. Number of prescriptions given last year, 288. Number of outside visits made last year, 20. Cost of conducting dispensary last year, $50.00. Delegate, Phineas J. Montgomery, M. D.

Kentucky.

Free Dispensary of Southwestern Homœopathic College, Louisville, Ky Incorporated 1892. Opened for patients 1892.

Maryland.

Maryland Homœopathic Hospital and Free Dispensary, Baltimore, Md. Incorporated 1890. Opened for patients 1890. Executive officer, John T. Graham, 223 St. Paul street, Baltimore, Md. Number of patients treated last year, 7,131. Number of prescriptions given last year, 14,340. Number of outside visits made last year, 4,748. Delegate, Henry J. Evans, M. D.

Southern Homœopathic College Dispensary, Baltimore, Md. Incorporated 1890. Opened for patients 1891. Executive officer, William Dulaney Thomas, M. D., 633 Carrollton avenue, Baltimore, Md. Number of patients treated last year, 2,916. Number of prescriptions given last year, 6,131. Number of

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outside visits made last year, 998. Cost of conducting dispensary last year, for drugs alone, $75.00. Delegate, Charles L. Rumsey, M. D.

Massachusetts.

Homœopathic Medical Dispensary, Boston, Mass. Incorporated 1856. Opened for patients 1857. Executive officer, A. Howard Powers, M. D., 406 Massachusetts avenue, Boston, Mass. Number of patients treated last year, 18,856. Number of prescriptions given last year, 49,979. Number of outside visits made last year, 9,358. Cost of conducting dispensary last year, $4,-926.39.

Homœopathic Medical Dispensary, Burrough's Place Branch, Boston, Mass. The statistics for this dispensary are included in those given for the Homœopathic Medical Dispensary. No separate record is kept.

Homœopathic Medical Dispensary, West End Branch, Boston, Mass. The statistics for this dispensary are included in those given for the Homœopathic Medical Dispensary. No separate record is kept.

Lowell Homœopathic Free Dispensary, Lowell, Mass. Not incorporated. Opened for patients 1894. Executive officer, G. Forrest Martin, M. D., 17 Kirk street, Lowell, Mass. Number of patients treated last year, 450 (new ones). Number of prescriptions given last year, 2,731. Number of outside visits made, 90. Delegate, G. Forrest Martin, M. D. "Clinics are held, as before, in connection with the work of the Lowell General Hospital. We also have a district nurse at work, making visits and assisting physicians in worthy cases who are unable to pay for the services of a trained nurse."

Roxbury Homœopathic Dispensary, Roxbury, Mass. Incorporated 1887. Opened for patients 1887. Executive officer, William W. Davis, Norfolk House, Roxbury, Mass. Number of patients treated last year, 3,593. Number of prescriptions given last year, 14,631. Cost of conducting dispensary last year, $1,713.19.

Salem Homœopathic Dispensary, Salem, Mass. Not incorporated. Opened for patients 1900.

Worcester Homœopathic Hospital and Dispensary Association, Worcester, Mass. Incorporated 1885. Opened for patients 1880. Executive officer, Edgar A. Fisher, M. D., 25 Elm street, Worcester, Mass. Delegate, J. Marcus Barton, M. D. "The dispensary was closed the greater part of last year. The property is disposed of, but the organization is still in existence."

Minnesota.

University Homœopathic Free Dispensary, Minneapolis, Minn. Not incorporated, as it is the property of the State. Opened for patients 1888. Executive officer, Alonzo P. Williamson, M. D., 602 Nicollet avenue, Minneapolis, Minn. Number of patients treated last year, 2,589. Number of prescriptions given last year, 6,348. Number of outside visits made last year, 611. Cost of conducting dispensary last year, $300.00. Delegate, E. L. Mann, M. D.

Missouri.

Homœopathic Free Dispensary, St. Louis, Mo. Not incorporated. Opened for patients 1878. Executive Officer, James A. Campbell, M. D., 1729 Washington avenue, St. Louis, Mo. Number of patients treated last year, 4,308. Number of prescriptions given last year, 10,219. Number of outside visits

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made last year, 220. Cost of conducting dispensary last year, $420. Delegate, James A. Campell, M. D.

Dispensary of Good Samaritan Hospital and Asylum, of St. Louis, Mo. Not incorporated. Opened for patients 1889. Executive Officer, H. A. Uhlemeyer, M. D., 1511 East Grand avenue, St. Louis, Mo. Number of patients treated last year, 452. Number of prescriptions last year, 1,565. Delegate, T. Griswold Comstock, M. D.

New Jersey.

West Jersey Dispensary and Hospital Association, Camden, N. J. Incorporated 1887. Opened for patients 1887.

East Orange Dispensary, Orange, N. J. Incorporated 1883. Opened for patients 1883. Executive Officer, Miss Laura M. Lindsley, 115 Washington street, East Orange, N. J. Number of patients treated last year, 979. Number of prescriptions given last year, 2,075. Cost of conducting dispensary last year, $294.63.

Passaic City Dispensary and Hospital, Passaic, N. J. Incorporated 1895. Opened for patients 1896.

St. Mary's Hospital Dispensary, Passaic, N. J.

New York.

Albany City Homœopathic Hospital and Dispensary, Albany, N. Y. Incorporated 1867. Opened for patients 1867.

Brooklyn Homœopathic Hospital Dispensary, Brooklyn, N. Y. Incorporated 1859. Opened for patients 1859. Executive Officer, William Lathrop Love, M. D., 1188 Dean street, Brooklyn, N. Y. "The dispensary has been closed for extensive alterations and repairs. The hospital is now a city institution, under city control, and it is expected that it will be opened for the reception of patients, together with the dispensary, about June 1st, 1902."

Brooklyn, E. D. Homœopathic Dispensary, Brooklyn, N. Y. Incorporated 1872. Opened for patients 1872. Executive Officer, George V. Tompkins, 96 Wilson street, Brooklyn, N. Y. Number of patients treated last year, 7,811. Number of prescriptions given last year, 27,914. Cost of conducting dispensary last year, $2,500.

Central Homœopathic Dispensary, Brooklyn, N. Y. Incorporated 1883. Opened for patients 1883.

Gates Avenue Homœopathic Dispensary, Brooklyn, N. Y. Incorporated 1867. Opened for patients 1867. Executive Officer, D. R. Aldridge, 32 Burling Slip, New York City. Number of patients treated last year, 1,729. Number of prescriptions given last year, 7,179. Minor surgical operations, 427. Vaccinations, 55. Number of outside visits made last year, 283. Cost of conducting dispensary last year, $706.25.

Memorial Dispensary, Brooklyn, N. Y. Incorporated 1894. Opened for patients 1880. Executice Officer, Mary L. Lines, M. D., 285 Washington avenue, Brooklyn, N. Y. Number of patients treated last year, 2,808. Number of prescriptions given last year, 5,879. Number of outside visits made last year, 811. Cost of conducting dispensary last year, $1,583.16. Delegate, Hattie C. Van Buren, M. D. "Since the new dispensary law restricting dispensary patients has been in force, our dispensary work has fallen off very much."

Twenty-sixth Ward Homœopathic Dispensary, Brooklyn, N. Y. Incorporated 1894. Opened for patients 1894. Eexecutive Officer, George J. Jardin, 2730 Atlantic avenue, Brooklyn, N. Y. Number of patients treated last year,

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1,161. Number of prescriptions given last year, 1,947. Cost of conducting dispensary last year, $297.08. Delegate, H. O. Rockefeller, M. D.

Homœopathic Hospital and Dispensary, Mount Vernon, N. Y. Incorporated 1896. Opened for patients 1895. Executive Officer, William B. Davis, M. D., "The Chester," 42 Park avenue, Mount Vernon, N. Y. Number of patients treated last year, 132. Number of prescriptions given last year, 210. Delegate, William B. Davis, M. D.

Hahnemann Hospital, Out Door Department, New York City. Incorporated 1875. Opened for patients 1891. Executive Officer, George W. Roberts, M. D. Number of patients treated last year, 1,665. Number of prescriptions given last year, 4,426. Delegate, George W. Roberts, M. D.

Dispensary of the New York Medical College and Hospital for Women, New York City. Incorporated 1863. Opened for patients 1864. Executive officer, Mrs. H. L. Bender, 816 Marcy avenue, Brooklyn, N. Y. Number of patients treated last year, 392. Number of prescriptions given last year, 1,013. Delegate, Henry M. Dearborn, M. D.

New York Ophthalmic Hospital, Out Door Department, New York City. Incorporated 1852. Opened for patients 1852. Executive officer, Frank H. Boynton, M. D., 36 West Fiftieth street, New York City. Number of patients treated last year, 14,243. Number of prescriptions given last year, 48,962. Cost of conducting dispensary last year, $26,848. This includes the cost of conducting the hospital. Delegate, Frank H. Boynton, M. D.

Homœopathic Free Dispensary, Rochester, N. Y. Incorporated 1887. Opened for patients 1889. Executive officer, Granger A. Hollister, Rochester, N. Y. Number of patients treated last year, 1,484. Number of prescriptions given last year, 3,769. Delegate, Edwin H. Wolcott, M. D.

Ohio.

Free Dispensary of Ohio Hospital for Women and Children, Cincinnati, Ohio. Incorporated 1881. Opened for patients 1881. Executive officer, E. D. Albro, Wyoming, Ohio. Number of patients treated last year, 407. Number of prescriptions given last year, 884. Cost of conducting dispensary last year, $150. Delegate, Ida E. McCormick, M. D.

Homœopathic Free Dispensary, Cincinnati, Ohio. Incorporated 1867. Opened 1867. Executive officer, Charles E. Walton, M. D., Eighth and John streets, Cincinnati, Ohio. Number of patients treated last year, 3,511. Number of prescriptions given last year, 14,127. Number of outside visits made last year, 402. Delegate, Charles E. Walton, M. D. "The work last year was decreased in consequence of fire in college building."

Homœopathic Eye and Ear Dispensary, Cincinnati, Ohio. Incorporated 1867. Opened for patients 1867. Executive officer, Thomas M. Stewart, M. D., 704 Elm street, Cincinnati, Ohio. Number of patients treated last year, 5,031. Number of prescriptions given last year, 8,337. Number of outside visits made last year, 912. Delegate, Thomas M. Stewart, M. D.

Good Samaritan Dispensary, Cleveland, Ohio. Incorporated 1849. Opened for patients 1849. Executive officer, J. Richey Horner, M. D., "The Osborn," Cleveland, Ohio. Number of patients treated last year, 9,803. Number of prescriptions given last year, 17,062. Number of outside visits made last year, 371. Cost of conducting dispensary last year, $2,109. Delegate, J. Richey Horner, M. D.

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Oregon.

Dispensary of the Presbyterian Chinese Mission, Portland. Not incorporated. Opened for patients 1894. Executive officer, Mrs. W. S. Bolt, M. D., 350 Fourteenth street, Portland, Oregon. "No record has been kept of the work which was done during the past year."

Pennsylvania.

Children's Homœopathic Hospital Dispensary, Philadelphia, Pa. Incorporated 1877. Opened for patients 1877. Executive officer, Walter Strong, M. D., 2105 North Thirteenth street, Philadelphia, Pa. Number of patients treated last year, 35,218. Number of prescriptions given last year, 102,762. Number of outside visits made last year, 4,759. Delegate, Walter Strong, M. D.

Hahnemann Medical College Dispensary, Philadelphia, Pa. Incorporated 1848. Opened for patients 1848. Executive officer, Charles Mohr, M. D., Oak Lane, Philadelphia, Pa. Number of patients treated last year, 22,382. Number of prescriptions given last year, 123,190. Number of outside visits made last year, 2,115. Delegate, Charles Mohr, M. D.

St. Luke's Homœopathic Dispensary, Philadelphia, Pa. Incorporated 1895. Opened for patients 1895. Executive officer, Miss Mary E. Lewars, 84 Fisher's lane, Germantown, Philadelphia, Pa. Number of patients treated last year, 2,480. Number of prescriptions given last year, 14,584. Delegate, George W. Stewart, M. D.

Dispensary of the Woman's Homœopathic Association of Pennsylvania, Medical, Surgical and Maternity Hospital, Philadelphia, Pa. Incorporated 1882. Opened for patients 1883. Executive officer, Mrs. F. B. Skinner, Provident building, Philadelphia, Pa. Number of patients treated last year, 5,077. Number of prescriptions given last year, 14,640. Number of outside visits made last year, 1,953.

Woman's Southern Homœopathic Dispensary, Philadelphia, Pa. Incorporated 1896. Opened for patients 1896. Executive officer, Miss Annie M. Miller, 1911 Mount Vernon street, Philadelphia, Pa. Number of patients treated last year, 1,643. Number of prescriptions given last year, 2,108. Number of outside visits made last year, 465.

Reading Homœopathic Dispensary, Reading, Pa. Incorporated 1890. Opened for patients 1888. Executive officer, Henry F. Schantz, M. D., 402 North Fifth street, Reading, Pa. Number of patients treated last year, 2,418. Number of prescriptions given last year, 8,095. Delegate, Henry F. Schantz, M. D.

Rhode Island.

Providence Homœopathic Dispensary, Providence, R. I. Incorporated 1883. Opened for patients 1874. Executive officer, Charles W. Bowen, M. D., 194 Broadway, Providence, R. I. Number of patients treated last year, 333,313. Number of prescriptions given last year, 818. Delegate, Sayer Hasbrouck, M. D.

Virginia.

Richmond Homœpathic Free Dispensary Richmond, Va. Incorporated 1897. Opened for patients 1897.

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HOMŒOPATHIC JOURNALS IN THE UNITED STATES

American Physician. Established 1876. Published monthly, octavo form, by A. L. Chatterton & Co., 156 Fifth avenue, New York, N. Y. Edited by Frank Kraft, M. D., 57 Bell avenue, Cleveland, Ohio. Subscription price, $2.00. Sixty pages in each number.

American Medical Monthly. Established 1883. Published monthly, octavo form, by Fosnot & Williams, Baltimore, Md. Edited by Henry Chandlee, M. D., 704 West North avenue, Baltimore, Md. Subscription price, $1.00. Seventy-two pages in each number.

The Chironian. Established 1884. Published monthly, from October to May, inclusive, in quarto form, by the students of the New York Homœopathic College and Hospital, Avenue A and Sixty-third street, New York, N. Y. Edited by one of the members of the senior class of each year. Subscription price, $1.00. Twenty-six pages in each number.

The Cleveland Medical and Surgical Reporter. Established 1900. Published monthly, octavo form, by the Cleveland Homœopathic Medical College, Cleveland, Ohio. Edited by J. Richey Horner, M. D., "The Osborn," Cleveland, Ohio. Subscription price, $1.00. Eighty pages in each number.

The Clinic of Syracuse. Established 1898. Published monthly, quarto form, by E. Elmer Keeler, M. D., 452 South Salina street, Syracuse, N. Y. Edited by E. Elmer Keeler, M. D., 452 South Salina street, Syracuse, N. Y. Subscription price, 50 cents. Thirty-six pages in each number.

The Clinical Reporter. Established 1887. Published monthly, quarto form by W. W. Gilbert, M. D., 314 South Jefferson avenue, St. Louis, Mo. Edited by D. M. Gibson, M. D., 241 South Jefferson avenue, St. Louis, Mo. Subscription price, $1.00. Forty-eight pages in each number.

The Clinique. Established 1880. Published monthly, octavo form, by C. Gurnee Fellows, M. D., 70 State street, Chicago, Ill. Edited by Homer V. Halbert, M. D., 70 State street, Chicago, Ill. Subscription price, $2.00. Fifty pages in each number.

The Hahnemannian Advocate. Established 1895. Published monthly, octavo form, by The Hahnemann Publishing Co., 6704 La Fayette avenue, Chicago, Ill. Edited by Herman W. Pierson, M. D., 31 Washington street Chicago, Ill. Subscription price, $2.50. Sixty-four pages in each number.

The Hahnemann Institute. No report.

The Hahnemannian Monthly. Established 1865. Published monthly, octavo form, by The Hahnemannian Monthly (Inc.), 1506 Arch street, Philadelphia, Pa. Edited by Clarence Bartlett, M. D., 1506 Arch street, Philadelphia, Pa. Subscription price, $3.00. Ninety-two to one hundred and four pages in each number.

The Homœopathic Envoy. Established 1891. Published monthly, quarto form, by E. P. Anschutz, P. O. Box 921, Philadelphia, Pa. Subscription price, 25 cents. Eight pages in each number.

The Homœopathic Journal of Obstetrics, Gynecology and Pedology. Established 1879. Published bi-monthly, by A. L. Chatterton & Co., 156 Fifth avenue, New York, N. Y. Edited by William Francis Honan, M. D.,

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Sherman Square Hotel, New York, N. Y. Subscription price, $4.00. One hundred and sixteen pages in each number.

The Homœopathic Journal of Pediatrics. Established 1902. Published monthly, octavo form, by John C. Chadwick, M. D., 382 Franklin street, Buffalo, N. Y. Edited by John C. Chadwick, M. D., 382 Franklin street, Buffalo, N. Y. Subscription price, $1.00. Fifty-two pages in each number.

The Homœopathic News. Established 1871. Published monthly, octavo form, by F. August Luyties, 619 Locust street, St. Louis, Mo. Edited by Charles R. Vogel, M. D., 84 Wabash avenue, Chicago, Ill. Subscription price, $1.00. Sixty-four pages in each number.

The Homœopathic Recorder. Established 1886. Published monthly, octavo form, by Boericke & Tafel, 1011 Arch street, Philadelphia, Pa. Edited by E. P. Anschutz, P. O. Box 921, Philadelphia, Pa. Subscription price, $1.00. Forty-eight pages in each number.

The Journal of Advanced Therapeutics. Established 1880. Published monthly, octavo form, by A. L. Chatterton & Co., 156 Fifth avenue, New York, N. Y. Edited by Wm. B. Snow, M. D., 627 Lexington avenue, New York, N. Y. Subscription price, $3.00. One hundred pages in each number.

The Journal of Homœopathics. Established 1897. Published monthly, octavo form, by H. A. Cameron, M. D., 612 North Seventh street, Philadelphia, Pa. Edited by Alexander Villers, M. D., Dresden, Germany, and H. A. Cameron, M. D., 612 North Seventh street, Philadelphia, Pa. Subscription price, $2.00. Forty-eight pages in each number.

The Homœopathic Eye, Ear and Throat Journal. Established 1895. Published monthly, octavo form, by the editors. Edited by Arthur B. Norton, M. D., 16 West Forty-fifth street, New York, N. Y.; John B. Garrison, M. D., 111 East Seventieth street, New York, N. Y.; Charles H. Helfrich, M. D., 542 Fifth avenue, New York, N. Y., and George W. McDowell, M D., 542 Fifth avenue, New York, N. Y. Subscription price, $2.00. From thirty-two to sixty-four pages in each number.

The Journal of Ophthalmology, Otology and Laryngology. Established 1889. Published bi-monthly, octavo form, by A. L. Chatterton & Co., 156 Fifth avenue, New York, N. Y. Edited by John L. Moffat, M. D., 1136 Dean street, Brooklyn, N. Y. Subscription price, $4.00. Eighty-four pages in each number.

The Medical Advance. Established 1873. Published monthly, octavo form, by Henry C. Allen, M. D., 5142 Washington avenue, Chicago, Ill. Edited by Henry C. Allen, M. D., 5142 Washington avenue, Chicago, Ill. Subscription price, $2.00. Sixty pages in each number. "This journal is devoted entirely to the perpetuation and an aggressive struggle for pure homœopathy."

The Medical Arena. Established 1893. Published monthly, octavo form, by Anton E. Neumeister, M. D., 1218 Main street, Kansas City, Mo. Edited by Silas C. Delap, M. D., 1218 Main street, Kansas City, Mo. Subscription price, $1.00. Thirty-two pages in each number.

The Medical Century. Established 1893. Published monthly, royal octavo form, by Medical Century Co., New York, N. Y. Edited by Willis A. Dewey, M. D., Ann Arbor, Mich. Subscription price, $2.00. Thirty pages in each number.

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The Medical Counselor. Established 1881. Published monthly, octavo form, by Medical Counselor Publishing Club, 32 Adams avenue, West Detroit, Mich. Edited by Stephen H. Knight, M. D., 18 West Willis avenue, Detroit, Mich. Subscription price, $1.00. Forty pages in each number.

The Medical Era. Established 1883. Published monthly, quarto form, by Era Publishing Co., Chicago, Ill. Edited by Charles Gatchell, M. D., 100 State street, Chicago, Ill. Subscription price, $1.00. Forty-eight pages in each number.

The Medical Student. Established 1886. Published by A. S. Briggs, Box 105, Station A, Boston, Mass. Edited by H. M. Emmons, Box 105, Station A, Boston, Mass. Subscription price, $1.00. Forty-four pages in each number.

The Medical Visitor. Established 1884. Published monthly, octavo form, by Halsey Bros. Co., 95 Wabash avenue, Chicago, Ill. Edited by Wilson A. Smith, M. D., Morgan Park, Ill. Subscription price, $1.00. Sixty-four pages in each number.

The Minneapolis Homœopathic Magazine. No report.

The New England Medical Gazette. Established 1865. Published monthly, octavo form, by Otis Clapp & Son, 10 Park Square Boston, Mass. Edited by John L. Coffin, M. D., 229 Berkeley street, Boston, Mass., and A. Temple Laening, M. D. Subscription price, $2.00. Forty-eight pages of reading matter in each number.

The North American Journal of Homœopathy. Established 1852. Published monthly, octavo form, by Journal Publishing Club, Limited, 181 West Seventy-third street, New York, N. Y. Edited by Eugene H. Porter, M. D., 181 West Seventy-third street, New York, N. Y. Subscription price, $3.00. Seventy-two pages in each number.

The Pacific Coast Homœopathic Journal. No report.

HOMŒOPATHIC MEDICAL COLLEGES IN THE UNITED STATES

Hahnemann Hospital College of San Francisco. Incorporated 1883. Opened for students 1884. Dean, James W. Ward, M. D., 606 Sutter street, San Francisco, Cal. Length of each yearly course, eight and a half months, commencing in March of each year. Number of courses requisite for graduation 4; number of students in attendance the past year, 45; number of graduates at last commencement, 2; number of alumni belonging to the school, 152; number of faculty, 28; number of professors, 19; number of lecturers, 14. Value of college buildings and land, $25,000. Amount of endowment, $1,250. No debt. Amount of annual income, $3,500. Delegate, James W. Ward, M. D.

Denver Homœopathic College and Hospital, Denver, Col. Incorporated 1894. Opened for students 1894. Dean, James Polk Willard, M. D., Masonic Temple, Denver, Col. Length of each yearly course, seven months, commencing in September of each year. Number of courses requisite for graduation, 4; number of students in attendance the past year, 32; number of graduates at last commencement, 10; number of alumni belonging to the school, 56; number of faculty, 29; number of professors, 9; number of lecturers, 8.

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Value of college buildings and land, $35,000. No endowments. Amount of debt, $14,000. Delegates, James P. Willard, M. D.; David A. Strickler, M. D.

Hahnemann Medical College and Hospital of Chicago. Incorporated 1855. Opened for students 1860. Dean, E. Stillman Bailey, M. D., 31 Washington street, Chicago, Ill. Length of each yearly course, thirty weeks, commencing in September of each year. Number of courses requisite for graduation, 4; number of students in attendance the past year, 195; number of graduates at last commencement, 49; number of alumni belonging to the school, 2,267; number of faculty, 49; number of professors, 35; number of lecturers, 14. Value of college buildings and ground, $250,000. Amount of endowment, $100,000. Amount of debt, $45,000. Amount of annual income, $18,000. Delegates, E. Stillman Bailey, M. D.; W. Henry Wilson, M. D.

Chicago Homœopathic Medical College, Chicago. Incorporated 1876. Opened for students 1876. Dean, Allen C. Cowperthwaite, M. D., Marshall Field Building, Chicago, Ill. Length of each yearly course, seven months, commencing in September of each year. Number of courses required for graduation, 4. Number of students in attendance the past year, 160. Number of graduates at last commencement, 34. Number of alumni belonging to the school, 1,142. Number in faculty, 68. Number of professors, 19. Number of lecturers, 49. Value of college building and land, $125,000. Amount of debt, $25,000. No endowments. Amount of yearly income, $16,000. Delegate, Allen C. Cowperthwaits, M. D.

Hering Medical College, Chicago, Ill. Incorporated 1892. Opened for students 1893. Dean, Henry C. Allen, M. D., 5142 Washington avenue, Chicago, Ill. Length of each yearly course, seven months, commencing in September of each year. Number of courses requisite for graduation, 4; number of students in attendance the past year, 65; number of graduates at last commencement, 18; number of alumni belonging to the school, about 200; number of faculty, 33; number of professors, 20; number of lecturers, 13. Value of college buildings and land, $36,000. No endowment. Amount of debt, $6,000. Amount of yearly income, from $6,000 to $10,000. Delegates, Henry C. Allen, M. D.; Jay J. Thompson, M. D.

College of Homœopathic Medicine of State University of Iowa, Iowa City, Iowa. Not incorporated. Opened for students 1877. Dean, George Royal, M. D., 308 Good Block, Des Moines, Iowa. Length of each yearly course, 36 weeks, commencing in September of each year. Number of courses requisite for graduation, 4; number of students in attendance last year, 42; number of graduates at last commencement, 7; number of alumni belonging to the school, 248; number of faculty, 15; number of professors, 10; number of lecturers, 5. Cannot estimate the value of college buildings and land, as they are the property of the state. No endowment. No debt. Delegates, George Royal, M. D.; Frederick Becker, M. D.

Southwestern Homœopathic Medical College, Louisville, Ky. Incorporated 1892. Opened for students 1893.

Southern Homœopathic Medical College and Hospital, Baltimore, Md. Incorporated 1890. Opened to students, 1891. Dean, George T. Shower, M. D., 421 Roland avenue, Baltimore, M. D. Length of each yearly course, seven months, beginning on first Tuesday in October of each year. Number of courses requisite for graduation, 4; number of students in attendance the past

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year, 35; number of graduates at last commencement, 9; number of alumni belonging to the school, 85; number of faculty, 34; number of professors, 12; number of lecturers, 22. No endowment. Amount of annual income, $3,400. "The state has appropriated $2,500 per annum for the next two years." Delegates, Charles L. Rumsey, M. D.; J. B. Gregg Custis, M. D.

Boston University School of Medicine, Boston, Mass. Opened to students 1873. Dean, John P. Sutherland, M. D., 295 Commonwealth avenue, Boston, Mass. Length of each yearly course, thirty weeks, commencing the first week in October of each year. Number of courses requisite for graduation, four yearly ones; number of students in attendance the past year, 125; number of graduates at last commencement, 23; number of alumni belonging to the school, 880; number of faculty, 58; number of professors, 22; number of lecturers, 36; value of college buildings and land, $200,000. Amount of endowment, $48,000. No debt. Amount of annual income, $18,000. Delegates, John P. Sutherland, M. D.; Howard P. Bellows, M. D.

Homœopathic Medical College of the University of Michigan, Ann Arbor, Mich. Dean, Wilbert B. Hinsdale, M. D., Ann Arbor, Mich. Length of each yearly course, 38 weeks, commencing in September of each year. Number of courses requisite for graduation, 4; number of students in attendance the past year, 70; number of graduates at last commencement, 8; number of alumni belonging to the school, 500; number of faculty, 45; number of professors, 15; number of lecturers, 30. Value of college buildings and land, $300,000. No endowment; supported by the state. No debt. Amount of annual income, $30,000. Delegate, Wilbert B. Hinsdale, M. D.

Detroit Homœopathic Medical College, Detroit, Mich. Incorporated 1872. Opened for students 1872. Dean, Daniel A. MacLachlan, M. D., Majestic Building, Detroit, Mich. Length of each yearly course, 28 weeks, commencing in September of each year. Number of courses requisite for graduation, 4; number of students in attendance the past year, 45; number of graduates at last commencement, 6; number of alumni belonging to the school, not known; number of faculty, 31; number of professors, 18; number of lecturers, 13. Value of college buildings and land, $50,000. No endowment. Amount of debt, $15,000. Amount of annual income, $3,000. Delegates, D. A. MacLachlan, M. D.; J. M. Griffin, M. D.

College of Homœopathic Medicine and Surgery of the University of Minnesota. Incorporated 1888. Opened to students 1888. Dean, Alonzo P. Williamson, M. D., 602 Nicollet avenue, Minneapolis, Minn. Length of each yearly course, eight and a half months, commencing in September of each year. Number of courses requisite for graduation, 4; number of students in attendance the past year, 22; number of graduates at last commencement, 3; number of alumni belonging to the school, 67; number of faculty 14; number of professors, 14; number of lecturers, 8. The property belongs to the state. Delegates, George Franklin Roberts, M. D.; Eugene L. Munn, M. D.

Kansas City Homœopathic Medical College, Kansas City, Mo. Incorporated 1888. Opened to students 1888. Dean, S. H. Anderson, M. D., 1214 Main street, Kansas City Mo. Length of each yearly course, seven months, commencing in September of each year. Number of courses requisite for graduation, 4; number of students in attendance the past year, 24; number of graduates at last commencement, 3; number of alumni belonging to the school, 133;

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number of faculty, 31, number of professors, 10; number of lecturers, 21. Value of college buildings and land, $18,000. No endowment. No debt. Amount of annual income, $2,000. Delegates, Silas C. Delap, M. D.; Mark Edgerton, M. D.

Hahnemann Medical College of the Kansas City University, Kansas City, Mo. Incorporated 1896. Opened to students 1896. Dean, William H. Jenney, M. D., Broadway and Twelfth street, Kansas City, Mo. Length of each yearly course, seven months, commencing in September of each year. Number of courses requisite for graduation, 4; number of students in attendance the past year, 48; number of graduates at last commencement, 10; number of alumni belonging to the school, 34; number of faculty, 22; number of professors, 22. Value of college building and land, $5,600. No endowment. No debt. Amount of annual income, $1,700. "We will erect a new college building this year." Delegates, Moses T. Runnels, M. D.; William H. Jenney, M. D.

Homœopathic Medical College of Missouri, St. Louis, Mo. Incorporated 1857. Opeend to students 1860. Dean, Willis B. Morgan, M. D., 4208 North Grand avenue, St. Louis, Mo. Length of each yearly course, seven months, commencing in September of each year. Number of students in attendance the past year, 67; number of graduates at last commencement, 12; number of alumni belonging to the school, 672; number of faculty, 25; number of professors, 25; number of lecturers, 5. Value of college building and land, $3,000. No endowment. Amount of debt, $8,500. Amount of annual income, $3,190. Delegates, James A. Campbell, M. D.; Willis B. Morgan, M. D.

New York Homœopathic Medical College and Hospital, New York, N. Y. Incorporated 1860. Opened for students 1860. Dean, William H. King, M. D., 64 West Fifty-first street, New York, N. Y. Length of each yearly course, seven months, commencing on the first Tuesday in October of each year. Number of courses requisite for graduation, 4; number of students in attendance the past year, 112; number of graduates at last commencement, 23; number of alumni belonging to the school, 627; number of faculty, 28; number of professors, 27; number of lecturers, 21. Value of college building and land, $105,000. No endowment. Amount of debt, $175,000. Amount of annual income, $12,500.

New York Medical College and Hospital for Women, New York City. Incorporated 1863. Opened for students 1863. Dean, M. Belle Brown, M. D., 30 West Fifty-first Street, New York City. Length of each yearly course, twenty-six weeks, commencing in October of each year. Number of courses requisite for graduation, four. Number of students in attendance the past year, 33. Number of graduates at last commencement, 6. Number of alumni belonging to the school, 340. Number in faculty, 44. Number of professors, 24. Number of lecturers, 14. Delegates, William H. Kang, M. D., Sidney F. Wilcox, M. D.

Cleveland Homœopathic Medical College, Cleveland, Ohio. Incorporated 1850. Opened to students 1850. Dean, Gaius J. Jones, M. D., Caxton Building, Cleveland, Ohio. Length of each yearly course, twenty-eight weeks, commencing in September of each year. Number of courses requisite for graduation, 4; number of students in attendance the past year, 118; number of graduates at the last commencement, 25; number of alumni belonging to the school, 2,300; number of faculty, 51; number of professors, 28; number of lec-

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turers, 23. Value of college building and land, $150,000. Amount of endowments, $50,000. Amount of debt, $45,000. Amount of annual income, $12,000. Delegates, Gaius J. Jones, M. D.; Adolph B. Schneider, M. D.

Pulte Medical College, Cincinnati, Ohio. Incorporated 1872. Opened to students 1872. Dean, Jared D. Buck, M. D., 116 West Seventh street, Cincinnati, Ohio. Length of each yearly course, seven months, commencing on the first Wednesday in October of each year. Number of courses requisite for graduation, 4; number of students in attendance the past year, 40; number of graduates at last commencement, 10; number of alumni belonging to the school, 649; number of faculty, 29; number of professors, 20; number of lecturers, 9. Value of college building and land, $20,000. No endowment. Delegates, Jared D. Buck, M. D.; Charles E. Walton, M. D.

Hahnemann Medical College of Philadelphia. Incorporated 1848. Opened for students 1848. Dean, Pemberton Dudley, M. D., 1405 North Sixteenth Street, Philadelphia, Pa. Length of each yearly course, seven and a half months, commencing October 1st of each year. Number of courses requisite for graduation, four. Number of students in attendance last year, 269. Number of graduates at last commencement, 68. Number of alumni belonging to the school, 2,620. Number in faculty, 55. Number of professors, 16. Number of lecturers, 39. Value of college buildings and land, $1,114,240.00. Amount of endowments, $251,363.00. Amount of debt, $175,000.00. Delegates, Pemberton Dudley, M. D., Charles Mohr, M. D.

ADDITIONS TO REPORT OF COMMITTEE ON ORGANIZATION, REGISTRATION AND STATISTICS.

(Received too late for insertion in the preceding pages.)

STATE SOCIETIES

Arizona.

Arizona Homœopathic Medical Association. President, L. Hyde, M.D., Uhœnix, Ariz.; Secretary, William L. Woodruff, M. D., Phœnix, Ariz. "There are so few homœopathic physicians in Arizono that it is almost impossible to get them together, in consequence of their living at such distances from each other; we have had no meeting for two or three years, but our organization is still in existence."

Minnesota.

Minnesota State Homœopathic Institute. Organized 1867. Not incorporated. The annual meeting is usually held in Minneapolis, Minn. We have been unable to obtain any report this year, after repeated endeavors to get one. The officers for last year were: President, Henry W. Lufkin, M.D., Germania Bank Building, St. Paul, Minn.; secretary, Henry C. Aldrich, M. D., 313 Medical Block, Minneapolis, Minn.

Vermont.

Vermont Homœopathic Medical Society. Organized 1854. Incorporated 1858. We have been unable to obtain any report from this society this year. The officers last year were: President, E. E. Whitaker, M.D., Newport, Vt. Secretary, Walter H. Weeks, M. D., East Hardwick, Vt. The annual meeting is held in Montpelier, Vt. on the third Wednesday in May of each year. The semi-annual meeting is held in different cities in the State on the third Wednesday in October of each year.

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LOCAL SOCIETIES

Arkansas.

Little Rock Homœopathic Medical Society. Organized 1900. Not incorporated. The annual meeting is held in Little Rock, Ark. Monthly meetings are held in the same place. We have been unable to obtain any report from this society this year. The officers last year were: President, E. Darwin Ayres, M.D., Little Rock, Ark. Secretary, Gilbert V. Thomas, M.D., 516½ Main Street, Little Rock, Ark.

Pennsylvania.

Homœopathic Medical Society of Germantown. Organized 1877. Not incorporated. The annual meeting is held in Germantown, Philadelphia, Pa. in January of each year. Monthly meetings are held in the same place. We have been unable to obtain any report from this society for the last two years. At the last report, the officers were: President, Louis P. Posey, M.D., 1429 Walnut Street, Philadelphia, Pa. Secretary, James Harwood Closson, M.D., 53 West Chelten Avenue, Germantown, Philadelphia, Pa.

Hahnemann Medical Association. Organized 1900. Not incorporated. The annual meeting is held during the week preceding the opening of the annual session of Hahnemann Medical College of Philadelphia, of each year. We have been unable to obtain any report this year. The officrs at last report were: President, Henry S. Weaver, M.D., 1621 Chestnut Street, Philadelphia, Pa. Secretary, Charles A. Ayres, M.D., 1648 South Broad Street, Philadelphia, Pa.

HOMŒOPATHIC MEDICAL CLUBS

Georgia.

Atlanta Medical Club. Organized 1882. Not incorporated. The annual meeting is held in Atlanta, Ga., on the first Monday in June of each year. Monthly meetings are held in the same place on the first Monday in each month. President, Richard E. Hinman, M.D., 153 Whitehall Street, Atlanta, Ga. Secretary, Clarence M. Paine, M.D., 67 North Forsyth Street, Atlanta, Ga.

GENERAL HOMŒOPATHIC HOSPITALS

Delaware.

Homœopathic Hospital of Delaware, Wilmington. Incorporated 1888. Opened for patients 1888. Executive officer, Mrs. Emma G. Quigley, 601 West Eighth Street, Wilmington, Del. Number of beds, 42; number of patients treated last year 291. Value of hospital property, $25,000. Supported by annual subscriptions, donations and board of patients. Delegate, Lewis W. Flinn, M. D. "We are entirely free from debt, and contemplate making large additions to our hospital buildings. We have just installed a complete electric cabinet and X-ray outfit.'

Iowa.

St. Bernard's Hospital, Homœopathic Department, Council Bluffs, Iowa. Incorporated 1888. Opened for patients 1888. Executive officer, Mary Vincent, Mother Superioress. Number of beds, 100. Value of hospital property,

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$175,000. Supported by county appropriations, and board of private patients. Delegate, Phineas J. Montgomery, M.D. "We have an insane department as well as a general hospital. The homœopaths have the same privileges in both departments. The institution is about to be turned into a sanitarium for the treatment of nervous diseases; a large annex has been built about fifty yards away, for general hospital purposes. The cost of the superstructure was $75,000; when completed it will cost about $140,000.

Illinois.

Moline City Hospital, Moline, Ill. Number of beds, 50. Attending physician, August H. Arp, M. D., Moline, Ill.

Kentucky.

Southern Homœopathic Hospital, Louisvillle, Ky. Incorporated 1892. Opened for patients 1898. Executive officer, J. P. Bryan, M.D., 628½ Fourth Avenue, Louisville, Ky. Number of beds, 7; number of patients treated last year, 30. Supported by donations and by pay of patients. "This hospital is simply used to take care of patients operated upon during college term, at Saturday afternoon clinics, and only represents the number of patients having had major operations performed at those clinics."

Michigan.

Muskegon City Hospital, Muskegon, Mich. Incorporated 1892. Opened for patients 1892. Number of beds, 25. Executive officer, C. H. Hauber, City Hospital, Mich. Value of hospital property, $5,000. Supported by voluntary contributions.

Minnesota.

City Hospital, Homœopathic Department, Minneapolis, Minn. Number of beds, 130. This hospital is open to physicians of both schools of practice. Attending homœopathic physician, George E. Ricker, M. D., 75 Syndicate Block, Minneapolis, Minn.

St. Luke's Hospital, Homœopathic Department, St. Paul, Minn. Number of beds, 75. Value of hospital property, $100,000. Supported by pay of patients and donations. The medical staff is composed of physicians from both schools of practice and each have separate male and female wards.

Missouri.

Hospital for Women and Children, Homœopathic Department, Kansas City, Mo. Incorporated 1897. Opened for patients 1897. Executive officer, Avis E. Smith, M.D., 309 Commercial Building, Kansas City, Mo. Number of beds, 25. Supported by pay of patients. "This hospital is under the management of both homœopathic and allopathic physicians, and, so far, has been in every way a very great success."

St. Louis Children's Hospital, St. Louis, Mo. Incorporated 1879. Opened for patients 1880. Executive officer, Charles H. Goodman, M.D., 3329 Washington Avenue, St. Louis, Mo. Number of beds, 100; number of patients treated last year, 491. Value of hospital grounds, $30,000. Supported by voluntary contributions. Delegate, James A. Campbell, M.D.

New Jersey.

West Jersey Homœopathic Hospital, Camden, N. J. Incorporated 1887. Opened for patients 1887. Executive officer, William W. Knowlton, M.D., 13 South Sixteenth Street, Philadelphia, Pa. Number of beds, 25; number of patients treated last year, 140. Value of hospital property, $14,000. Supported by voluntary contributions. Delegate, Erving M. Howard, M.D. "Dur-

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ing the last year the adjoining building was purchased, and almost all paid for. An elevator is being put in and alterations made so that men can be received as well as women and children. Everything is going on very nicely, and with increased receipts, as well as the advance of homœopathy, for which we are deeply thankful."

Passaic General Hospital, Homœopathic Department, Passaic, N. J. Incorporated 1893. Opened for patients 1897. Executive officer, William H. Speer, Passaic, N. J. Number of beds, 35. Value of hospital property, $50,000. Supported by voluntary contributions.

Trenton Momœopathic Hospital, Trenton, N. J. Incorporated 1867. Opened for patients 1868. Executive Officer, A. K. Lenkel, Hamilton Avenue, Trenton, N. J. Number of beds, 50. Number of patients treated last year, 254. Value of hospital property, $100,000. Supported by private contributions and county appropriations. Delegate, E. B. Witt, M. D.

New York.

Albany City Homœopathic Hospital, Albany, N. Y. Incorporated 1867. Opened for patients 1868. Executive Officer, James W. Cox, 160 State Street, Albany, N. Y. Number of beds, 50. Value of hospital property, $25,000. Supported by city appropriations, private patients, and voluntary subscriptions.

Brooklyn Homœopathic Hospital, Brooklyn, N. Y. Incorporated 1852. Opened for patients 1858. Executive Officer, Frank W. Arnold, 117 Montague Street, Brooklyn, N. Y. Number of beds, 130.

Geneva City Hospital, Homœopathic Department, Geneva, N. Y. Incorporated 1889. Opened for patients 1898. Executive Officer, Charles A. Mellen, Geneva, N. Y. Number of beds, 18. Value of hospital property, $30,000. Supported by endowment, subscriptions, and voluntary donations. Delegate, N. B. Conant, M.D.

Hahnemann Hospital, Rochester, N. Y. Incorporated 1888. Opened for patients 1889. Executive Officer, Joseph A. Biegler, M. D., 58 South Clinton Street, Rochester, N. Y. Number of beds, 65. Number of patients treated last year, 246. Value of hospital property, $53,000. Supported by donations, City and County income, and from paying patients. Delegate, Joseph A. Biegler, M. D., "Within the past year the hospital has been enlarged to more than double its former capacity. It is situated upon one of the finest localities to be found in this country. It is as nearly perfect in its arrangements and outfit as can be made. The practice maintained is that of pure Homœopathy. The principal of Homœopathy is strictly adhered to, in accordance with the teachings of Hahnemann. We have had a long and hard struggle, which has resulted in the establishment of one of the most perfect and finest hospital to be found anywhere. This has all come to us without begging, without newspaper bombast, but the appreciation of the people of the true practice of Homœopathy."

Ohio.

Protestant Hospital, Homœopathic Department, Columbus, Ohio. Opened for patients 1892. Executive Officer, E. U. Seeds, Wesley Block, Columbus, Ohio. Number of beds, 125. Delegate, J. W. Clemmer, M. D. "This hospital is opened to physicians of all recognized schools of medicine."

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Deaconess Hospital, Homœopathic Department, Dayton, Ohio. Incorporated 1890. Opened for patients 1891. Executive Officer, H. F. Colby, M. D., Dayton, Ohio. Number of beds, 150. Number of patients treated last year, 1,119. Delegate, Frank Webster, M. D. Value of hospital property, $200,000. Supported by private subscriptions, and donations.

Mahoning Valley Hospital, Homœopatic Department, Youngstown, Ohio. Number of beds, 50. "This hospital is opened to physicians of all schools of practice, and every thing works perfectly harmoniously." Attending Homœopathic physician, Howard B. Hills, M. D., Youngstown, Ohio.

Zanesville City Hospital, Homœopathic Department, Zanesville, Ohio. Incorporated 1888. Opened for patients 1891. Executive Officer, Mrs. O. M. Townsend, Zanesville, Ohio. Number of beds, 28. Attending Homœopathic physician, Francis A. Smith, M. D.

Pennsylvania.

Hahnemann Hospital, Scranton, Pa. We have been unable to obtain any report from this hospital this year.

Wisconsin.

Milwaukee Hospital, Homœopathic Department, Milwaukee, Wis. This hospital is open to physicians of both schools of practice, and no separate records are kept.

PRIVATE AND SPECIAL HOMŒOPATHIC HOSPITALS

Illinois.

National Temperance Hospital, Homœopathic Department, Chicago, Ill. Incorporated 1886. Opened for patients 1886. Executive Officer, Lewis C. Fritts, M. D., 21 Ashland Boulevard, Chicago, Ill. Number of beds, 20. Supported by pay of patients. The hospital property is rented.

Chicago Baptist Hospital, Homœopathic Department, Chicago, Ill. Number of beds, 75. Attending Homœopathic physician, John P. Webster, M. D., 6254 Stewart Avenue, Chicago, Ill.

Englewood Union Hospital and Dispensary, Englewood, Ill. Incorporated 1895. Opened for patients 1896. Number of beds, 40. Supported by pay of patients. Attending Homœopathic physician, John P. Webster, M. D., 6254 Stewart Avenue, Chicago, Ill.

St. Joseph's Hospital, Homœopathic Department, Joliet, Ill. Number of beds, 100. This hospital is open to physicians of both schools of medicine. Attending Homœopathic physician, Henry M. Beckwith, M. D., 400 Western Avenue, Joliet, Ill.

Indiana.

Banning Orthopædic Institute, Fort Wayne, Ind. Not incorporated. Opened for patients 1896. Executive Officer, Edmond P. Banning, M. D., Fort Wayne, Ind. Number of beds, 12, in Fort Wayne, and 20 in Chicago, Value of hospital property, in Fort Wayne, $7,000; in Chicago, $12,000.

Epworth Hospital, Homœopathic Department, South Bend, Ind. Incorporated 1894. Opened for patients 1894. Executive Officer, Miss Maggie Brennan, South Bend, Ind. Number of beds, 50. Number of patients treated last year, 268. Value of hospital property, $81,000. Supported by pay patients and private subscriptions. Attending Homœopathic physician, Martha V. Thomas, M. D., 419 West Division Street, South Bend, Ind.

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Kentucky.

Patty A. Clay Infirmary, Richmond, Ky. We have been unable to obtain any report from this institution this year.

Massachusetts.

Cullis' Consumptives' Home, New Dorchester, Boston, Mass. Incorporated 1871. Opened for patients 1864. Executive Officer, Rev. E. D. Mallory, Cullis' Consumptives' Home, New Dorchester, Boston, Mass. Number of beds, 40. Number of patients treated last year 96; 90 in Consumptives' Home, 6 in Spinal Home. Value of hospital property, $208,000. Supported by voluntary gifts and legacies.

St. Botholf Hospital, Boston, Mass. Incorporated 1901. Opened for patients 1898. Executive Officer, Frederick W. Davis, M. D., 80 Huntington Avenue, Boston, Mass. Number of beds, 20. Value of hospital property, $30,000. Supported by pay of patients.

Leonard Morse Hospital, Natick, Mass. Attending physician, Winfield S. Smith, M. D., 845 Boylston Street, Boston, Mass. We have been unable to obtain any report from this hospital this year.

Morton Hospital, Homœopathic Department, Taunton, Mass. Number of beds, 20. Attending Homœopathic physician, Joseph W. Hayward, M. D., Taunton, Mass.

Michigan.

State Asylum, Iona, Mich. Opened for patients 1885. Executive Officer, Oscar R. Long, M. D., Ionia, Mich. Number of beds, 323. Value of hospital property, $250,000. Supported by State and County appropriations.

Borgess Hospital, Homœopathic Department, Kalamazoo, Mich. Number of beds, ——. This hospital is open to physicians of both schools of medicine. Attending Homœopathic physician, James N. Ayres, M. D., Kalamazoo, Mich.

Ohio.

Chillicothe Hospital, Homœopathic Department, Chillicothe, Ohio. Executive Officer, John P. Phillips, Chillicothe, Ohio. Number of beds, 7. Value of hospital property, $7,000. Supported by pay of patients and voluntary contributions. Attending Homœopathic physician, Charles Hoyt, M. D., Chillicothe, Ohio.

Dr. Barnhill Sanitarium and Hospital, Findlay, Ohio. Not incorporated. Opened for patients 1898. Executive Officer, Tobias G. Barnhill, M. D., Findlay, Ohio. Number of beds, 22. Number of patients treated last year, 114. Value of sanitarium property, $25,000. Supported by pay of patients. "We do some surgery, but most of our success comes from the study of the Homœopathic Materia Medica. Our treatment of the 'Narcotic Habit' is strictly in accordance with Homœopathic principles as taught by Hahnemann.'

Rhode Island.

Channing Hospital, Providence, R. I. Incorporated 1899. Opened for patients 1899. Executive Officer, Waldo H. Stone, M. D., 133 Orms Street, Providence, R. I. Number of beds, 50. Value of hospital property, $25,000. Supported by pay of patients. Delegate, Sayer Hasbrook, M. D. "Although this hospital is under Homœopathic control and management, yet any physician has the privilege of treating a patient there."

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Maryland.

Dr. Irving Miller's Sanitarium, Baltimore, Md. Not incorporated. Opened for patients 1895. Executive Officer, Irving Miller, M. D., 1734 St. Paul Street, Baltimore, Md. Number of beds, 25. Number of patients treated last year, 497. Value of sanitarium property, $20,000. Supported by pay of patients. Delegate, Irving Miller, M. D.

INSTITUTIONS UNDER HOMŒOPATHIC TREATMENT

Arizona.

Indian School, Phoenix, Arizona. Attending physician, Charles D. Belden, M. D., Phoenix, Arizona. We have been unable to obtain any report from this institution this year.

Illinois Asylum for Feeble-minded Children, Chicago. Executive Officer, William L. Anthon, M. D., Lincoln, Ill. Number of beds, 600. We have been unable to obtain any report from this institution this year.

Indiana.

Old Ladies' Home, New Albany, Ind. Executive Officer, Mrs. Rebecca Culbertson, Louisville, Ky. Number of beds, 14. Value of institution property, $10,000. Supported by an endowment fund. Attending physician, G. Oscar Erni, M. D., New Albany, Ind.

Iowa.

Home for Aged Women, Cedar Rapids, Iowa. Incorporated 1887. Opened for inmates 1887. Executive Officer, G. T. Averill, Cedar Rapids, Iowa. Number of beds, 20. Number of patients treated last year, 10. Value of institution property, $45,000. Supported by admission fees of inmates, and interest on $30,000 endowment. Delegate, Charles H. Cogswell, M. D.

Home for the Friendless, Cedar Rapids, Iowa. Incorporated 1886. Opened for inmates 1886. Executive Officer, Mrs. G. L. Van Vechtten, Cedar Rapids, Iowa. Number of beds, 45. Number of patients treated last year, 10. Value of institution property, $20,000. Supported by voluntary contributions. Delegate, Charles H. Cogswell, M. D.

Des Moines Home for Friendless Orphans, Des Moines, Iowa. Incorporated 1887. Opened for inmates 1884. Executive Officer, Mrs. C. E. Rawson, Des Moines, Iowa. Number of beds, 50. Attending physician, Alexander M. Linn, M. D. Value of institution property, $18,000.

Sioux City Training School for Nurses, Sioux City, Iowa. Incorporated 1894. Opened for inmates, 1894. Executive Officer, Mrs. W. Stinson, Sioux City, Iowa. Number of beds, 45. Value of institution property, $30,000. Supported by fees from patients. Attending physician, A. Perry Bowman, M. D.

Maryland.

Baltimore, City Jail, Baltimore, Md. Attending physician, James C. Clarke, M. D., 1201 Madison Avenue, Baltimore, Md. We have been unable to obtain any report from this institution this year.

Minnesota.

Washburne Memorial Asylum, Minneapolis, Minn. Incorporated 1881. Opened for inmates 1886. Executive Officer, Hon. C. E. Faulkner, Minneapolis, Minn. Number of beds, 120. Value of institution property, $180,000. Supported by the bequest of the founder, Hon. Cadwallader C. Washburne, amounting to $484,000.

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Sheltering Arms, Minneapolis, Minn. Incorporated 1882. Opened for inmates 1882. We have been unable to obtain any report from this institution this year.

Church Home of Minnesota for Aged and Infirm Women, St. Paul, Minn. Incorporated 1897. Opened for inmates 1896. Executive Officer, Miss Louisa S. Rees, 414 East Fourteenth Street, St. Paul, Minn. Number of beds, 10.

Missouri.

Bethel Mission, Kansas City, Mo. Attending physician, Charles S. Elliott, M. D., 1103 Main Street, Kansas City, Mo. We have been unable to obtain any report from this institution this year.

Protestant Home for Aged Women, Kansas City, Mo. Attending physician, Charles S. Elliott, M. D., 1103 Main Street, Kansas City, Mo. We have been unable to obtain any report this year from this institution.

Girl's Industrial Home, St. Louis, Mo. Incorporated 1854. Opened for inmates 1854. Executive Officer, Mrs. J. H. Barnard, St. Louis, Mo. Number of beds, 100. Attending physician, William J. Gunderlach, M. D.

New Jersey.

Baptist Home for the Aged, Newark, N. J. Incorporated 1891. Opened for inmates 1891. Number of beds, 29. Executive Officer, Mrs. Sutphen, 64 Elizabeth Avenue, Newark, N. J. Attending physician, Henry J. Anderson, M. D., 4 Orange Place, Newark, N. J.

Old Ladies' Home, Newark, N. J. We have been unable to obtain any report from this institution this year.

Newark Orphan Asylum, Newark, N. J. Attending physician, Henry J. Anderson, M. D., 4 Orange Place, Newark, N. J.

New York.

Albany House of Shelter, Albany, N. Y. Incorporated 1869. Opened for inmates 1868. Executive Officer, Samuel S. Hatt, 86 State Street, Albany, N. Y. Number of beds, 23. Value of institution property, $25,000. Supported by interest from investments, voluntary contributions, and the revenue from county charges.

Ingleside Home, Buffalo, N. Y. Attending physician, William H. Marcy, M. D., 1148 Main Street, Buffalo, N. Y. We have been unable to obtain any report from this institution this year.

New York Christian Home for Intemperate Men, New York. Incorporated 1875. Opened for inmates 1875. Executive Officer, Mrs. William E. Dodge, New York City. Number of beds, 90.

Ohio.

Logan County Children's Home, Bellefontaine, Ohio. Attending physician, Joseph H. Wilson, M. D., Bellefontaine, Ohio.

Shelby County Children's Home, Sidney, Ohio. Opened for inmates 1897. Executive Officer, J. H. McClung, Sidney, Ohio. Number of beds, 42. Number of patients treated last year, 20. Value of institution property, $60,000. Supported by county tax and private donations. Attending physician, A. W. Reddish, M. D. "During the year we had an epidemic of impetigo contagiosum, and also of trichophytosis capitis, diseases rarely found in private practice."

Pennsylvania.

Christian Home for Women, Allegheny, Pa. Incorporated 1872. Opened

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for inmates 1872. Executive officer, Mrs. M. G. Slater, 133 Locust Street, Allegheny, Pa. We have been unable to obtain any report from this institution this year.

HOMŒOPATHIC DISPENSARIES

Delaware.

Homœopathic Free Dispensary, Wilmington, Del. Incorporated 1888. Opened for patients 1888. Executive officer, Mrs. Emma G. Quigley, 601 West Eighth Street, Wilmington, Del. Number of patients treated last year, 601. Number of prescriptions given last year, 3,108. Delegate, Lewis W. Flinn, M. D.

Illinois.

National Free Dispensary, Chicago, Ill. Executive Officer, Paul Burmaster, M. D., 441 Dearborn Avenue, Chicago, Ill. We have been unable to obtain any report from this dispensary for this year.

Working Women's Free Dispensary, Chicago, Ill. We have been unable to obtain any report from this dispensary for this year.

Englewood Union Hospital and Dispensary, Englewood, Ill. We have been unable to obtain any report from this dispensary this year.

Kentucky.

Free Dispensary of Southwestern Homœopathic College, Louisville, Ky. Incorporated 1892. Opened for patients 1892. Executive Officer, J. T. Bryan, M. D., 628½ Fourth Ave., Louisville, Ky. Number of patients treated last year, 209. Number of prescriptions given last year, 528. Number of outside visits made last year, 125. Cost of conducting dispensary last year, $75.00.

Michigan.

The Grace Hospital Dispensary, Detroit, Mich. Incorporated 1888. Opened for patients 1888. Executive Officer, Ransom Gillis, Detroit, Mich. We have been unable to obtain any report from this dispensary for this year.

Missouri.

St. Louis Children's Hospital Dispensary, St. Louis. Incorporated 1879. Opened for patients 1880. Executive Officer, Charles H. Goodman, M. D., 3329 Washington Avenue, St. Louis, Mo. Number of patients treated last year, 787. Number of prescriptions given last year, 2114. Delegate. James A. Campbell, M. D.

New Jersey.

West Jersey Dispensary and Hospital Association, Camden, N. J. Incorporated 1887. Opened for patients 1887. Executive Officer, O. L. Grumbrecht, M. D., Camden, N. J. Number of patients treated last year, 568. Number of prescriptions given last year, 19,280. Number of outside visits made last year, 3,953. "The dispensary did a very excellent work last year, and it is held in very high esteem by the city officials and by the public generally."

Passaic City Dispensary and Hospital, Passaic, N. J. Executive Officer, Henry Speer, Passaic, N. J. Incorporated 1895. Opened for patients 1896. We have been unable to obtain any report from this dispensary for this year.

New York.

Albany City Homœopathic Hospital and Dispensary, Albany, N. Y. In-

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corporated 1867. Opened for patients 1868. Executive Officer, James W. Cox, 160 State Street, Albany, N. Y. We have been unable to obtain any report from this dispensary for this year.

Central Homœopathic Dispensary, 298 Howard Avenue, Brooklyn, N. Y. Executive Officer, Mrs. M. L. Campbell, 298 Howard Avenue, Brooklyn, N. Y. We have been unable to obtain any report from this dispensary for this year.

New York Homœopathic Medical College and Hospital, Out Door Department, New York City. Incorporated 1861. Opened for patients 1861. Executive Officer, Charles A. Mitchell, M. D., 2026 Seventh Avenue, New York City. Number of patients treated last year, 3,918. Number of prescriptions given last year, 10,121. Number of outside visits made last year, 1,725. Delegate, Frederick K. Hollister, M. D.

Ohio.

Free Medical and Surgical Dispensary for Women and Children, Cleveland, Ohio. Incorporated 1895. Opened for patients 1878. Executive Officer, Martha M. Stone, M. D., 914 Prospect Street, Cleveland, Ohio. Number of patients treated last year, 1,309. Number of prescriptions given last year, 1,998. Number of outside visits made last year, 725. Cost of conducting the dispensary last year, $8,995.00. Delegate, Martha M. Stone, M. D.

Pennsylvania.

Homœopathic Medical and Surgical Hospital and Dispensary of Pittsburg, Pa. Incorporated 1866. Opened for patients 1866. Executive Officer, G. T. Stewart, 1019 Liberty Avenue, Pittsburg, Pa. Number of patients treated last year, 4,732. Number of prescriptions given last year, 16,658. Number of dressings last year, 7,064. Delegate, James M. McClelland, M. D.

Virginia.

Richmond Homœopathic Free Dispensary, Richmond, Va. Incorporated 1897. Opened for patients 1897. Executive Officer, Mrs. H. W. Bassett, 502 West Grace Street, Richmond, Va. We have been unable to obtain any report from this dispensary for this year.

RECAPITULATION.

Number of National Societies	9
Number of Sectional and Interstate Societies	3
Number of State Societies	34
Number of Local Societies	93
Number of Medical Clubs	43
Number of Alumni Associations	8
Number of Miscellaneous Medical Associations	3
Number of General Hospitals	84
Number of Special and Private Hospitals	61
Number of Sanitariums	58
Number of Institutions under Homœopathic Treatment	66
Number of Dispensaries	56
Number of Medical Colleges	20
Number of Homœopathic Medical Journals	31

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GRADUATES OF HOMŒOPATHIC MEDICAL COLLEGES, 1902

HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF CHICAGO.

For the year 1901-2. Session Commenced September 9, 1901. Session Closed April 17, 1902
Number of weeks 30. Matriculates 175. Graduates 49. Commencement April 17, 1902.

Name	Residence	Age	Preceptor	Time of study Yrs.	Number of Courses Attended and, Where.
Appleton, Egbert G. .	Muskegon, Mich. .	25	C. L. Thompson,	4	4, Hahn. M. C., Chi. A. B. Milton Col.
Barker, Frank Marion	North Loup, Neb.	27	F. O. Burdick, MD.	4	3, Hahn. M. C., Chi.
Birney, E. Stockton .	Washington, D. C.	22	So. Homeo. M. C. .	4	2, Hahn. M. C. Chi. 2, So. Homeo. M. C.
Bradwell, J. Barton . .	Chicago, Ill	23	Katherine B. Clapp M. D.	4	4, Hahn. M. C., Chi. 2, Homeo M. D., S U. of Iowa.
Bower, Curtis E.	West Union, Ia. . . .	24	State Uniy. of Ia. .	4	2, Hahn. M. C., Chi. A. M. Victoria Un.
Bray, H. Truro, A. M. B. D., LL. D.	Chicago, Ill.	54	National M. C.	4	2, Nat. M., 2, HahnC. Chi., Vet. McGill C
Burke, Rob. Henry . .	Derby Line, Vt. . . .	27	Cleveland H. M. . .	4	1, Phys. & Surg. Col. Baltimore, 1Clev. Homeo, Med.
Burke, Rob. Henry . .	Derby Line, Vt. . . .	27	Cleveland H. M. . . .	4	1, Hahn. M. G., Chi. 2, Homeo, M. D., S. U. of Iowa.
Carolus, W. Isaac . . .	Sterling, Ill.	28	State Univ. of Ia .	4	2, Hahn. M. C., Chi.
Chapin. A Dewey	Baraboo, Wis. . . .	lgl.	Faculty	4	4, Hahn. M. C., Chi.
Charles, Clayton H. . .	Woodstock, Ill. . . .	23	J. W. Primm M. D.	4	4, Hahn. M. C., Chi.
Clapp, Hubert Barton	Chicago, Ill.	24	E. Stillman Bailey M. D.	4	4, Hahn. M. C., Chi.
Coffey, D. Fletcher. . .	Newman, Ill.	24	F. J. Scott, M. D. . .	4	4, Hahn. M. C., Chi. 2, Homeo, M. D., S. U. of Iowa.
Conklin. Winfred E. . .	Olney, Ill.	24	M. D. Foster, M. D	4	4. Hahn. M. C.. Chi.
Cooper, Wm. Alonzo .	Davenport, Iowa . .	25	State Univ. of Ia. .	4	2, Hahn. M. C., Chi. 3, Chicago Homeo.
Darnall, Herbert O. . .	Lebanon, Ind.	25	Chicago Homeo. . .	4	1, Hahn. M. C., Chi. B. S. & Ph. G. Val.
Davis, Delmer L.	Bloomfield, Iowa . .	25	Faculty		3, Hahn. M. C., Chi. 4, Woman's Medical
Downer, Mary A., M D.	River Falls, Wis. . .	. .	Woman's Medical.	5	1, Hahn. M. C., Chi.
Fuller, Agnes Virginia	Columbus, Wis. . .	lgl.	B. F. Bellack, M. D.	4	4, Hahn. M. C., Chi.
Garber, C. Alice	Flora, Ill.	28	N. W. Bowman, M D.	4	4, Hahn. M. C., Chi. B. L. Milton Col.
Hemphill, Wm. J.	Eau Claire, Wis. . .	28	E. J. Crandall, M. D.	4	3, Hahn. M. C., Chi.
Howard, A. Cordelia .	Elkader, Iowa . . .	21	H. S. Patterson, M D.	4	4, Hahn. M. C.,Chi.
Hunt, Edward S.	Chicago, Ill.	47	W. A. McDowell, M D.	4	4, Hahn. M. C., Chi. 2, H. M. D., S. U. I.
Jackson, Jas. M.	Orient, Iowa	27	State Univ. of Ia. .	4	2, Hahn. M. C., Chi. B. S.
Leeds, Arthur L., B. S	Mich. City, Ind. . . .	32	Faculty	4	3, Hahn. M. C., Chi. 2, Hahn. M. C., Phia.
Main, Daniel C.	Plainfield, N. J. . .	25	Hahn. of Phila. . . .	4	2, Hahn. M. C., Chi. 4, Chi. Homeo.
Milroy, William	Glasgow, Scot.	39	Chicago Homeo. . . Kirksville C. Osteo.	5	1, Hahn. M. C., Chi. 2, Osteo. C. & Ill St. Board.
Mullins, J. Melvin	Omaha, Mo.	29	Ill. State Board of Health	4	License, 2, Hahn. M. C. Chicago.
Olmstead, Arch. C. . . .	Lapeer, Mich.	24	W. H. Fanning, M. D.	4	4, Hahn. M. C., Chi.
Olmsted, Austin O. . .	Green Bay, Wis. . .	21	A. F. Olmsted, M. D. D.	4	4, Hahn. M. C., Chi.
Porath, Wm. C.	Newell, Iowa	28	J. H. Lawrence, M. D.	4	4, Hahn. M. C., Chi.
Probasco, Harriet G. .	Chicago, Ill.	37	J. W. Streeter, M. D.	4	4, Hahn. M. C., Chi.
Reed, Winifred S.	Chicago, Ill.	lgl.	Jos. P. Cobb. M. D	4	4. Hahn. M. C., Chi. 1, American Med.
Rhoads, Lewis Thos. .	Lincoln, Ill.	26	M. G. Owen, M. D.	4	3, Hahn. M. C., Chi. 3, Col. Med. & Surg
Shawl, J. Lester	Chicago, Ill.	35	Col. of M. & Surg. .	4	1, Hahn. M. C., Chi. 1, Harvey M. C.
Sikes. Edward W.	Waupun, Wis. . . .	26	Nat. M. C.	4	2, Nat. Med Col.

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Sikes, Edward W.....	Waupun, Wis. ...	26	Nat. Med. College..	4	1, Hahn. M. C., Chi. B. S.
Sheldon, A. Rufus ...	Norwalk, O.....	24	C. A. Mills, M. D ..	4	3, Hahn. M. C., Chi. 2½, Hom. C., St. L.
Skinner, Edward H...	St. Louis, Mo.	21	Hom. Col., St. L. .	4½	2, Hahn. M. C., Chi. 3, Hom. M. Dept. U of Minn.
Smith, N. Marshall...	Monticello, Iowa .	26	Univ. of Minn. ...	4	1, Hahn. M. C., Chi. 3, Boston U. S. of M
Staniford, Ed. Read. .	Boston, Mass.	27	Boston U. S. of M. .	4	1, Hahn. M. C., Chi. B. S.
Stewart, Frank W. . .	Grove City, Pa....	23	C. S. Ames, M. D. .	4	3, Hahn. M. C., Chi. B. S.
Stewart, Oliver Eug. .	Chicago, Ill.	27	M. R. Melendy, M. D.	4	3. Hahn. M. C., Chi. 3, Col. Med. & Surg.
Stoddard, Clara May..	Spirit Lake, Ia. ...	22	Col. of M. & Surg. .	4	1, Hahn. M. C., Chi.
Stone, Felix B.	Wabash, Ind.....	34	G. W. LaSalle, M. D.	4	4, Hahn. M. C., Chi.
Strong, Elmer D.	Aberdeen, S. Dak. .	27	Kent, Kamerer, M D.	4	4, Hahn. M. C., Chi.
Strong, W. Bryant . .	Waukesha, Wis. ..	40	O. W. Carlson, M. D.	4	4, Hahn. M. C., Chi.
Thompson, Fred Eug.	Evart, Mich.	30	E. S. Richardson, M. D.	4	4, Hahn. M. C., Chi.
Washburn, Geo. U. ..	Morris, Ill.	22	M. C. Sturtevant .	4	4, Hahn. M. C., Chi.

HAHNEMANN MEDICAL COLLEGE OF KANSAS CITY UNIVERSITY.
(FORMERLY COLLEGE OF HOMEOPATHIC MEDICINE AND SURGERY.)

For the year 1901-1902. Session Commenced September 9, 1901. Session Closed April 15 1902. Number of weeks 28. Matriculates, 48. Graduates, 10. Commencement, April 15 1902.

Name	Residence	Age	Preceptor	Time of Stdy Yrs.	Number of Courses Attended, and Where.
1. Bash, Carolyn S. ..	Taylor, Wis.....	34	Lloyd G. Van Scoyoc, M. D.	4	See Paragraph 1.
2, Bungardt, C. S. ..	Kansas City, Mo...	25	H. M. Fryer, M. D.	4	See Paragraph 2.
3, Cowhick, R. A. . .	Mitchell, S. Dak. .	48	W. A. Forster, MD	4	See Paragraph 3.
4, Dodson, Jno. P. . .	Independence, Mo.	36	W. D. Foster, M.D		See Paragraph 4.
5, Keeton, R. B.	Pueblo, Colo.. . ..	45	Frank Elliott, MD.	4	See Paragraph 5.
6, Lindberg, B. W. .. M. D.	Kansas City, Mo...	34			See Paragraph 6.
7, Mahaffy, A. DeWitt	Kansas City, Mo...	37	W. D. Foster, M D		See Paragraph 7.
8, Parker, J. A., ... D. D. S.	Kansas City, Mo...	28	F. Elliott, M. D. ..		See Paragraph 8.
9, Wilhelm, Levi R... M. D.	Kansas City, Mo...	37			See Paragraph 9.
10, Woods, S. DelosE,	Council Grove, Ks.	25	H. M. Fryer, M. D.		See Paragraph 10.

1: Bash. Attended four courses in the Hahnemann Medical College of the Kansas City University,

2: Bungardt. Attended three courses Kansas City Homoeopathic Medical College and one course in the Hahnemann Medical College of Kansas City University.

3: Cowhick. Attended four courses in the Hahnemann Medical College of the Kansas City University.

4: Dodson. Graduated from Columbian School of Osteopathy, Medicine and Surgery, Kirksville, Mo., four courses of five months each. One course Kansas City Homoeopathic Medical College and was admitted to the Junior class in this College. Passed successfully all the examinations at the close of the session. His average percentage was 96. Passed successfully the examination of the State Board of Health of Missouri. One course in the Hahnemann Medical College of the Kansas City University.

5: Keeton. Four courses in the Hahnemann Medical College of the Kansas City Univ.

6: Lindberg. Graduated at the Eclectic Medical College ,Cincinnati, Ohio, 1890.

7: Mahaffy. Graduated from the American School of Osteopathy, Kirksville, Missouri, 1897. Two courses in Kansas City Homoeopathic Medical College. One course in the Hahnemann Medical College of the Kansas City University.

8: Parker. Graduated at the Western Dental College ,Kansas City Missouri. One course in Columbian Medical College, Kansas City, Missouri. Two courses in Hahnemann Medical College of the Kansas City University.

9: Wilhelm. Graduate of the Eclectic Medical University, Kansas City, Missouri, 1900. One course in the Hahnemann Medical College of the Kansas City University.

10: Woods. One year in State University of Iowa. Two courses in Kansas City Homoeopathic Medical College. One course in the Hahnemann Medical College Kansas City University

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CHICAGO HOMEOPATHIC MEDICAL COLLEGE.

For the year 1901-2. Session Commenced September 25, 1901. Session Closed April 22, 1902
Number of weeks 28. Matriculates 131,. Graduates, 34. Commencement, April 22, 1902.

Name.	Residence	Age	Preceptor	Time of Stdy Yrs.	Number of Courses Attended and Where
Amerson, Geo. C.	Austin, Ill.	23	E. J. George M. D.	4	4, Chi. H. M. C.
Bisson, Martin	Chaarleston, Ill.	24	Wm. H. Lycan, M. D.	4	4, Chi. H. M. C. 2. Pulte M. C., Cin.
Bailey, Wm. H.	Chili Sta. N. Y.	28	M. D. Van Horn, M. D.	4	2, Chi. H. M. C.
Cheney, Carl L.	Oregon, Ill	26	B. E. Fahrney, M. D.	4	4, Chi. H. M. C.
Carr, Wm. H. (B. S.)	Bays, Ohio	25	E. P. Thomas, M. D.	4	4, Chi. H. M. C.
Cole, Henry S.	Rockton, Ill.	23	A. L. Bushby, M. D.	4	4, Chi. H. M. C.
Chaffee, O. L. (B. S.)	Mt. Vernon Ia.	25	Jas. Carson, M. D.	4	3, Chi. H. M. C. Advanced 1 yr acct. degree.
Durham, C. J.	Vermontville, Mich	24	F. H. Snell, M. D.	4	4, Chi. H. M. C.
Draper, Fannie.	Minard, Mich.	29	A. Kimball M. D.	4	1. Nat. M. C., Chi. 2, Dunham M. C., Chi
Drake, Jas. H.	Chicago, Ill.	24	E. C. Sweet, M. D.	4	1, Chi. H. M. C. 1, Nat. M. C., Chi. 2, Dunh. M. C., Chi. 1, Chi. H. M. C.
Fox, Clarence P.	Viroqua, Wis.	26	H. J. Suttle, M. D.	4	4, Chi. H. M. C.
Gardner, Wilfred	Bloomington, Ill.	24	W. E. Neiberger M D.	4	4, Chi. H. M. C.
Hallen, H. (Ph. G.)	Eau Claire, Wis.	23	A. Thorne, M. D.	4	3, Chi. H. M. C. Advanced 1 yr. acct degree.
Hash, Wm. E.	Chicago, Ill.	32	J. H. Crockett. M. D.	4	1, Nat. M. C., Chi. 2, Dunh. M. C., Chi. 1, Chi. H. M. C.
Hash, E., dept. C.	Chicago, Ill.	30	Jane H. Miller, M. D.	4	1, Nat. M. C., Chi. 2, Dunh. M. C., Chi. 1, Chi. H. M. C.
Lathrop, Wm. C.	Marion, Iowa	26	E. G. Ditmer, M. D.	4	2, U. of I. H. M. C. 2, Chi. H. M. C.
Logsdon, Wm. T. (M. D.)	Rockport, Ind.	43		3	2, U. of Louisville M. dept. 1889 1, Chi. H. M. C.
Lipscomb, Jas. W. (M. D.)	Chicago, Ill.	44		5	3, Nat. M. C., Chi. 1, Dunh. M. C., Chi. 1, Chi. H. M. C.
Mera, Frank E.	Detroit, Mich.	22	C. C. Miller M. D.	4	4, Chi. H. M. C.
Moorhead, Arthur C. (B. A.)	Fredonia, Pa.	27	T. T. Hogue, M. D.	4	3, Chi. H. M. C. Advanced 1 yr. acct. B.fA.
McAbee, Daniel H.	Indianapolis, Ind.	21	J. S. Martin, M. D.	4	4, Chi. H. M. C.
McRoberts, Wm. A.	Joliet, Ill.	34	W. R. McGuffin, M. D.	4	1, Nat. M. C., Chi. 2, Dunh. M. C., Chi. 1, Chi. H. M. C.
Pulliam, S. B.	Owenton, Ky.	31	R. W. Birchett, M. D.	4	4, Chi. H. M. C.
Parsons, P. L. (M. D.)	Traer, Iowa	26		5	4, U. of I. H. M. C. 1, Chi. H. M. C.
Peach, Chas. E.	Allegheny, Pa.	23	L. H. Willard, M. D.	4	2. Pulte M. C., Cin. 1, Dunh. M. C., Chi. 1, Chi. H. M. C.
Replogle, Wm. H.	Pontiac, Ill.	25	P. S. Replogle, M. D.	4	1, Chi. M. C., (N. W. University). 3, Chi. H. M. C.
Sweet, Edward A.	Butte City, Mont.	22	J. E. Cowperthwaite, M. D.	4	4, Chi. H. M. C.
Suder, J. F. (B. S.)	Jerry City, Ohio	26	J. F. Wallam, M.D	4	4, Chi. H. M. C.
Scholz, Emma L.	Lake Zurich, Ill.	27	Dr. Morehouse.	4	1, Nat. M. C. Chi. 2, Dunh. M. C., Chi. 1, Chi. H. M. C.
Shearburn, Edwin W.	Mendota, Ill.	35	A. P. Shearburn, M. D.	4	1, Nat. M. C., Chi. 2, Dunh. M. C., Chi. 1. Chi. H. M. C.
Schnepff, Albert	Chicago, Ill.	23	Thos. O. Butler, M D.	4	1, Nat. M. C., Chi. 2, Dunh. M. C., Chi. 1, Chi. H. M. C.
West, Edmund S.	Greenburg, Ind	22	D. W. Weaver, M. D.	4	4, Chi. H. M. C.
West, Wm. F.	Greenburg, Ind.	30	D. W. Weaver, M. D.	4	4, Chi. H. M. C.
Woodward, Stillman	Osage, Iowa	26	C. C. Wiggin, M. D	4	1. U. of I. H. M. C 3, Chi. H. M. C.

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HOMEOPATHIC MEDICAL COLLEGE, OF THE UNIVERSITY OF MICHIGAN.
For the year 1901-2. Session Commenced October 1, 1901. Session Closed June 19, 1902.
Number of weeks, 38. Matriculates, 70. Graduates, 8. Commencement, June 19, 1902.

Name	Residence	Age	Preceptor	Time of Stdy Yrs.	Number of Courses Attended, and Where.
Imus, H. L.	Ann Arbor, Mich.		H. M. C. of U. of M.	4	4, H. M. C. of U., M.
Levy, F. H. M. M. D.	Eaton Rapids, Mch		H. M. C. of U. of M.	4	1. H. M. C. of U., M.
Petion, R. J.	Oakwood, Mich.		H. M. C. of U. of M.	4	4, H. M. C. of U., M.
Lamb, G. L.	Ann Arbor, Mich		H. M. C. of U. of M.	4	4, H. M. C. of U., M.
Hayens, H. A.	Ann Arbor, Mich.		H. M. C. of U. of M.	4	4, H. M. C. of U., M.
Johnsen, C. E.	LaPorte, Ind.		H. M. C. of U. of M.	4	4, H. M. C. of U., M.
Schultz, F. J.	Ft. Wayne, Ind.		H. M. C. of U. of M.	5	5, H. M. C. of U., M.
Walker, E. D.	Ann Arbor, Mich.		H. M. C. of U. of M.	4	4, H. M. C. of U., M.

BOSTON UNIVERSITY SCHOOL OF MEDICINE.
For the year 1901-2. Session Commenced October 3, 1901, Session Closed June 4, 1902.
Number of weeks 32. Matriculates, 39. Graduates, 23. Commencement, June 4, 1902.

Name	Residence	Age	Preceptor	Time of Stdy Yrs.	Number of Courses Attended, and Where.
Abbott, S. E., Ch. B.	Andover.	23	Boston U. S. of M.	4	4, B. U. S. of Med.
Blackmore, R. Jr.	Boston	36	Boston U. S. of M.	4	4, B. U. S. of Med.
Blaney, C. A.	Dorchester,	22	Boston U. S. of M.	4	4, B. U. S. of Med.
Briggs, A. S., A. B.	Boston	30	Boston U. S. of M.	3	3, B. U. S. of M. and full course A. B. Y.
Briggs, M. L.	Athol	23	Boston U. ,S. of M.	4	4, B. U. S. of Med.
Capen, E. W.	Strughton	26	Boston U. ,S. of M.	3	3, B. U. S. of Med. Full course in Mass. C of Agri. 1, C. Phys and Surg, Boston
Emmons, H. M.	Kittery Pt. Me.	26	Boston U. S of M.	4	4, B. U. S. of Med.
Evans, J. H.	Rochester, N. H.	24	Boston U. S. of M.	4	4, B. U. S. of Med.
Ferguson, F. A., Ch. B	Allston	26	Boston U. S. of M.	4	4, B. U. S. of Med.
Grant, W. V., Ch. B	Mill View, P. E. I.	28	Boston U. S. of M.	4	4, B. U. S .of Med.
King, Sara Ella	Tapleyville	38	Boston U. S. of M.	4	4, B U. S. of Med.
Leavitt, M. A., A. B.	Somerville	25	Boston U. S. of M.	3	3, B. U. S. of M. and full course for A. B at Mt. Holyoke C
Maynard, H. E.	Waltham	23	Boston U. S. of M.	4	4, B. U. S. of Med.
Roberts, F. E.	Boston	22	Boston U. S. of M.	4	4, B. U. S, of Med.
Sargent, O. F. L.	Lawrence	25	Boston U. S. of M.	4	4, B. U. S. of Med.
Savage, Grace G.	Hubbardston	32	Boston U. S. of M.	4	4, B. U. S. of Med.
Sedgley, F. R.	Boston	23	Boston U. S. of M.	4	4, B. U. S. of Med .
Sugimoto, J., M. D.	Tokio, Japan	34	Boston U. S. of M.	3	3, B. U. S. of M. and full course for M.D at Tokio Med. Coll.
Surry, Alice G.	Neponset	28	Boston U. S. of M.	4	4, B. U. S. of Med.
Swope, O. C., Ch. B.	Blue Spgs., Neb.	25	Boston U. S. of M.	4	4, B. U. S. of Med.
Taylor, M. E.	Alex. Bay, N. Y.	28	Boston U. S. of M.	4	4, B. U. S. of Med.
Tilton, Nellie Noris	Brockton	35	Boston U. S. of M.	4	4, B. U. S. of Med.
Webster, A. B., A. B.	Coldbrook, N. S.	29	Boston U. S. of M.	3	3, B. U. S. of M. and full course for A B at Acadia College.

SOUTHERN HOMEOPATHIC MEDICAL COLLEGE AND HOSPITAL.
For the year 1901-2. Session Commenced October 1, 1901. Session Closed April 30, 1902.
Number of weeks, 30. Matriculates, 35. Graduates, 9. Commencement, May 6, 1902.

Name	Residence	Age	Preceptor	Time of Stdy Yrs.	Number of Courses Attended, and Where.
Barkdoll, F. L.	Waynesboro, Pa.	23	Dr. G. Gaver	4	2, Nat. N. U. S. of M. Ohio. 2, So. Hom. M. Coll.
Erb, F. Hervey	Reistertown, Ma.	43	So. H. M. Coll.	4	4, So. H. Med .Coll.
Evans F. L. A.	Montreal, Canada.	30	Dr. H. M. Patton	4	2, U. B. C. F. of Med. Montrea,l 2, So. Hom .Med. C
Goodson, C. M.	Hyattsville, Md.	27	So. H. M. Coll.	4	4, So. Hom. Med. C.
Hanby, Chas. M.	Wilmington, Del.	28	Dr. S.C . Frederick:	4	4. So. Hom. Med. C.
Keech, Henry H.	Baltimore, Md.	32	Dr. R. W. Mifflin	4	4, So. Hom. Med. C.
Mac Callum, M. J.	Bradford, Pa.	24	Dr. C. S. Hubbard	5	4, Bal. Med. Coll. 1, So. Hom. Med. C.
Walton, Henry J.	Baltimore, Md.	23	Dr. O. Ed. Janney	4	4, So. Hom. Med. C.
Wright, N. V.	Baltimore, Md.	24	So. H. M. Coll.	5	4, Bal. U. S. of Me ,1 So. Hom. Med.

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NEW YORK MEDICAL COLLEGE AND HOSPITAL FOR WOMEN.
For the year 1902. Session Commenced October 2, 1901. Session Closed May 14, 1902.
Number of weeks 28. Matriculates, —. Graduates, 6. Commencement, May 14, 1902.

Name	Residence	Age	Preceptor	Time of Stdy Yrs.	Number of Courses Attended, and Where.
Butterworth, M. E. ..	19 W. 21 St., N. Y.	32		3	2 at W. Coll. of Infer 1 at Cornell.
Pearson, Mary C.	241 E. 84 St., N. Y.	32		4	4 at N. Y. M. C. & H. for Women.
Whittemore, Daisy ..	32 W. 24 St., N. Y	25		4	4 at N. Y. M. C. &]H for Women.
Sutherland, Jane	141 W. 17 St., N. Y	35		4	4 at N. Y. M. C. & H for Women.
Rundio, E. L.	So. Orange, N. J. .	24		4	4 at N. Y. M. C & H for Women.
Urvenski, Anna	2510 Amsterdam Av. N. Y.	24		4	1, W. M. C., Phia. 3 at N. Y. M. C. H. for Women.

PULTE MEDICAL COLLEGE.
For the year 1901-2. Session Commenced Octcber 2, 1901. Session Closed May 6, 1902.
Number of weeks, 28. Matriculates 40. Graduates, 10. Commencement, May 6, 1902.

Name	Residence	Age	Preceptor	Time of Stdy Yrs.	Number of Courses Attended, and Where.
Ballard, A. E.	Birmingham, Ala.	25	A. N. Ballard, M. D.	4	Pulte College.
Anthony, B. V. H. ...	Cincinnati, O.	26	E. M. Kirk, M. D. .	4	Pulte College.
Buck, Chas, R.	Cincinnati, O.	25	J. D. Buck, M. D. .	4	Pulte College.
Morris, Wm. T.	Wheeling, W. Va. .	23	J. W. Morris, M. D	4	Pulte College.
Reed, Ralph.....	Middletown, O. ...	22	T. E. Reed, M. D. .	4	Lebanon & Pulte C.
Franks, Clara B.	N. Y. City, N. Y. .	34	E. M. Kirk, M. D. .	4	Pulte College.
Strasburg, C. A.	Criderville, O.	40	Practitioner	4	Cin. M., Ill. M., Pulte
Stowell, F. A.	Lawrence, Mass. ..	39	W. T. Findley, M. D.	4	Pulte College.
Wilms, Jno. H.	Cincinnati, O. . .	23	H. H. Wiggers, M. D.	4	Pulte College.
Stephan, Otto	Cincinnati, O.	34	Faculty Pulte	4	Pulte College.

HERING MEDICAL COLLEGE CHICAGO.
For the year 1901-2. Session Commenced September 10, 1901. Session Closed April 11, 1902
Number of weeks 28. Matriculates, 65. Graduates, 13. Commencement, April 11, 1902.

Name	Residence	Age	Preceptor	Time of Stdy Yrs.	Number of Courses Attended, and Where.
Wallace, Paul:.	California	25	College.....	4	D. O. degree, Licenti State Bd. Health ½ Course Harv. Coll. 1, Jr. H. D. U. M. 1, Hering.
Tenley W. A.....	Chicago, Ill.	26	Edith T. Clark ...	5	2, Keokuk Med. Coll 3, Hering
Aldrich, H. L.	Dover, Kas.	30	Dr. F. M. B. Jackson	4	1, Kansas Med. Coll. 3, Hering.
Carr, C. T.	Millington, Ill. ...		J. W. Carr	4	4, Hering.
Lindner, E. R.	Chicago, Ill	28	C. E. Henry		D. O. degree, Licenti. Bd. Health. 2, Hering.
Hopkins, V.....	Chicago, Ill.	24	H. C, Allen	4	4, Hering.
Podgarsky, F. S.				6	4. Univ. of Vienna. 2, Hering.
Donahoe, Nora	Chicago, Ill.	30	E. N. Waine	4	4, Hering
Kuznik, M.	Chicago, Ill.	30	College.....	4	1, Denver. 1, Harvey. 2, Hering.
Simon, C. E.	Chicago, Ill.	26	College.....	4	4, Hering.
Vishanoff, D.	Chicago, Ill.	24	College.....	5	4, Hahn of P. 1, Hering.
Evans, F. M.	Chicago, Ill.	24	College.....	4	4, Hering.
Weeks, W. W.				5	3 Rush Med. 2, Hering.

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HOMEOPATHIC MEDICAL COLLEGE OF MISSOURI.

For the year 1901-2. Session Commenced September 10, 1901. Session Closed April 17, 1902.
Number of weeks, 28. Matriculates, 67. Graduates, 12. Commencement, April 17, 1902.

Name	Residence	Age	Preceptor	Time of Stdy Yrs.	Number of Courses Attended, and Where.
Bohanan, Burton	Lynville, Ind.	25	Dr. Frank Camp	4	H. M. C. of Mo.
Bohanan, Clyde C.	Lynville, Ind.	27	Dr. Frank Camp	4	H. M. C. of Mo.
Baird, Sam'l L.	Moseyville, Ky.	26	Dr. J. W. Baird		
Clark, John	Deepwater, Mo.				
Cormack, Maud	Fredonia, Kas.	24	Dr A. W. Cormack	4	H. M. C. of Mo.
Higson, J. W., A. B.	St. Louis, Mo.	40	Dr. L. C. McElwer	4	1, U. C., adv. alld. for 3, H. M. C. of Mo.
Nothdurft, Daniel H.	Tilsit, Mo.	25	Dr. R. E. Schoen	4	H. M. C. of Mo.
O'Malley, Jno. J.	Louisville, Ky.	30	Dr. A. L. Boyce	4	H. M. C. of Mo.
Price, Jno. M.	Champion, Neb.	46	Dr. M. E. Lyman	4	H. M. C. of Mo.
Klosterman, W. H.	Okawville, Ill.	30	Dr. J Klosterman.	4	H. M. C. of Mo.
Robertson, J. W., M. D.	Coulterville, Ill.	41	Dr. D. S. Booth		Grad. Beau. Hosp. Med. College. 1, H. M. C. Mo.
Williamson, Wm. H.	Butler, Ill.	28	Ec. Med. Insti	4	2, Electric Med. Inst 2, H. M. C. of Mo.

HAHNEMANN MEDICAL COLLEGE OF THE PACIFIC.

For the year 1901. Session Commenced May 15, 1901. Session Closed December 5, 1901.
Number of weeks, 28. Matriculates 12. Graduates, 2. Commencement December 12, 1901

Name	Residence	Age	Preceptor	Time of Stdy	Number of Courses Tttendded, and Where.
Robbins, O. M. B.	Phoenix, Ariz.	25	Hahn M. C., Chi.	4	2, Denver H. M. of C 2. Hahn. of the Pac.
Smith, Julia A.	Wadsworth, Nev.	55	Hahn. M. C., Pac.	4	Hahn M. C., Pacific.

CLEVELAND HOMEOPATHIC MEDICAL COLLEGE.

For the year 1901-2. Session Commenced September 18, 1901. Session Closed April 9, 1902.
Number of weeks, 28. Matriculates, 118. Graduates, 25. Commencement, April 9, 1902.

Name	Residence	Age	Preceptor	Time of Stdy Yrs.	Number of Courses Attended, and Where.
Andersen, A. W.	Warren, Penn.	22	J. M. Davies, M. D	4	4, Clev. H. M. Coll.
Burns, Wm. H.	Brush Creek. Penn	23	H. J. Boyd, M. D.	4	4, Clev. H. M. Coll.
Carvell, Frank R.	Cleveland, Ohio	42	G. H. Quay, M. D.	4	4, Clev. H. M. Coll.
Case, R. A.	Cleveland, Ohio	27	T. D. Foljambe, M D.	4	4, Clev. H. M. Coll.
Dean, Ed. W.	Cleveland, Ohio	35	Faculty	4	4, Clev. H. M. Coll.
Esley, Ernest E.	Lincoln, N. Y.	31	G. W. Gurnee, M. D.	4	4, Clev. H. M. Coll
Ewing, R. Ross	New Sheffield. Pa.	34	Faculty	4	3, Clev. Med. Coll. 1, Clev, H. M. Coll.
Farber, Chas, K.	Cleveland Ohio	24	H. H. Baxter, M.D.	4	4, Clev. H. M. Coll.
Grant, E. McK.	Barbados, W. Ind's	37	C. I. Motley, M. D.	4	4, Clev. H. M. Coll.
Hemington, J. G.	Medina, Ohio	27	G. J.Damon, M. D.	4	1, Clev. Univ. M. & S 3, Clev. H. M. Coll.
Hirzel, W. C.	Cleveland, Ohio	36	A. B. Schneider, M: D.	4	2, W. Res. U. M. S.D. 2, Clev. H. M. Coll.
Jones, Geo. W.	Cleveland, Ohio	30	G. J. Jones, M. D.	4	4, Clev, H. M. Coll.
Jend, Wm. Jas.	Cleveland, Ohio	25	G. A. Jend. M. D.	4	4, Clev. H. M. Coll.
King, J. H.	Cleveland, Ohio	51	L. E. Hitchcock,	4	4, Clev. H. M. Coll.
King, G. S.	Cleveland, Ohio	33	L. E. Hitchcock, M. D. M. D.	4	4, Clev. H. M. Coll.
Kneale, Wm. Ed.	Despatch, N. Y.	25	N. T. B. Nobles, M: D.	4	4, Clev. H. M. Coll.
Livermore, R. Fay	New Haven, Conn.	28	Hry. P. Sage, M. D.	4	4, Clev. H. M. Coll.
McCoy, C. L.	Service, Penn.	29	O. E. Engle, M. D.	4	4, Clev. H. M. Coll.
Morrow, Jas. C.	Bellevue, Ohio	39	J. F. Miller, M. D.	4	2. Clev. H. H. Coll. 2, Clev. H. M. Coll.
Newland, F. H.	Clifton, Spgs. N. Y	28	L P. Conley, M. D	4	4, Clev. H. M. Coll.
Price, M. E.	Cleveland, Ohio	31	K. B. Waite, M. D.	4	4, Clev, H M. Coll.
Root, Geo. Wm.	Fonthill, Ontario	21	J. O. Emmett, M.D:	4	4, Clev. H. M. Coll.
Taylor, Allan A.	Metamora, Ohio	22	Geo. F. Frasch, M. D.	4	4, Clev. H. M. Coll.
White, Chas, E.	Salem, Ohio	28	M. H. White, M. D	4	4, Clev. H. M. Coll.
Wyckoff, W. H.	Chagrin Falls, O.	27	J. C. Steel, Jr. M.D.	4	4, Clev. H. M. Coll.

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COLLEGE OF HOMEOPATHIC MEDICINE UNIVERSITY OF THE STATE OF IOWA.

For the year 1901-2. Session Commenced September 12, 1901. Session Closed April 1, 1902
Number of weeks, 28 Matriculates, 42. Graduates, 7. Commencement, April 1, 1902

Name	Residence	Age	Preceptor	Time of study Yrs.	Number of Courses Attended, and
Alden, George H.	Des Moines, Iowa	26	C. H. M., S. U. I.	4	All at S. U. I.
Clapp, A. B.	Davenport, Iowa	22	C. H. M., S. U. I.	4	All at S. U. I.
Cogswell, C. H. Jr.	Cedar Rapids, Ia.	22	C. H. M., S. U. I.	6	All at S. U. I.
Crew, A. E.	Marion, Iowa	24	C. H. M., S. U. I.	4	All at S. U. I.
Fullmer, B. E.	Marshalltown Ia.	27	C. H. M., S. U. I.	4	1, at Drakellmants. 3, at S. U. I.
McDowell, G. T.	Woonsocket, S. D.	25	C. H. M., S. U. I.	4	All at S. U. I.
Page, C. V.	Iowa City	24	C. H. M., S. U. I.	6	All at S. U. I.

Cogswell and Page took the six years combined course getting two degrees. Cogswell B. S. and M. D.
Page getting B. A. and M. D

KANSAS CITY HOMEOPATHIC MEDICAL COLLEGE.

For the year 1901-2. Graduates, 3.

Name	Residence	Age	Preceptor	Time of Stdy Yrs.	Number of Courses Attended, and Where
Koogler, John H.	Kansas City, Mo.	50	Dr. Sutfin.	4	1, Ia. State Univ. 3, K. C. H. M. C.
Harms, Albert	St, Joseph. Mo.	24	Dr. W. J. Bell	4	2, Ens. M. C., St. J. 2, K. C. H. M. C.
Boland, Miss S. J.	Kansas City, Mo.	22	Dr. J. T. Boland	4	4, K. C. H. M. C.

DENVER HOMEOPATHIC COLLEGE.

For the year 1901-2. Session Commenced September 19, 1901. Session Closed April 22, 1902.
Number of weeks, 29. Matriculates, 32. Graduates, 10. Commencement, April 24, 1902

Name	Residence	Age	Preceptor	Time of Stdy Yrs.	Number of Courses Attended, and Where.
Williams, Jennette	Denver, Col.		Denver Hom. Coll.		4, Denver
Church, Lucius	Lafayette, Col.		Denver Hom. Coll.		2, in Cal., 2, in Den.
Church, Mabel	Lafayette, Col.		Denver Hom. Coll.		2, in Cal., 2, in Den.
Pitts, Solils O.	Denver, Col.		Denver Hom. Coll.		4, in Denver.
Swan, Albert T.	Brighton, Col.		Denver Hom. Coll.		4, in Denver.
Bowie, Robert G.	Avondale, Col.		Denver Hom. Coll.		3, Hahn. Chi. 1, Den
Cramer, Norman A.	Denver, Col.		Denver Hom. Coll.		3, K. C., 1, Denver.
Leslie, Samuel B.	O. Kmulgie I. T.		Denver Hom. Coll.		4, Denver.
Roosevelt, Giles F.	Denver, Col.		Denver Hom. Coll.		5, in Denver.
Daniels, Jas. H.	Snowball, Ark.		Denver Hom. Coll.		2, in So. somewhere 2, in D. H. C. and2, elsewhere.

COLLEGE OF HOMEOPATHIC MEDICINE AND SURGERY OF UNIVERSITY OF MINNESOTA.

For the year 1901-2. Session Commenced September 16, 1901. Session Closed June 1, 1902.
Number of weeks, 36. Matriculates, 22. Graduates, 3. Commencement, June 5, 1902.

Name	Residence	Age	Preceptor	Time of Stdy Yrs.	Number of Courses Attended, and Where.
Hall, Earl Lester	Eau Claire, Wis.	25	Univ. of Minn.	4	4 Univ. of Minn.
Rogers, Fred. D.	St. Paul, Minn.	32	Univ. of Minn.	4	4, Univ. of Minn.
Warner, Eug. Fred.	St. Paul, Minn.	23	Univ. of Minn.	4	4, Univ. of Minn.

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DETROIT HOMEOPATHIC COLLEGE.

For the year 1901-2. Session Commenced September 25, 1901 Session Closed April 22, 1902
Number of weeks, 28. Matriculates, 45. Graduates, 6. Commencement, April 22, 1902

Name	Residence	Age	Preceptor	Time of Stdy Yrs.	Number of Courses Attended, and Where.
Martin, Chas. A.	Charlotte, Mich. . .	26	S. J. Allen, M. D. .	4	3, yrs. at D. H. C. 1, year Preparatory.
Strain, Chas. S.	Columbus Grove, O	31	H. T. Breckbrill M. D.	4	3, years at D. H. C. 1 yr. for Scientific work and degree.
Wendt, L. F. C.	Detroit, Mich.	26	R. C. Rudy, M. D.	4	3 yrs. at D. H. C. 1 yr. for Scientific work and degree.
Way, Francis M.	Detroit, Mich.	39	R. E. Gustin, M. D	4	1 yr. Mich. Coll. M. 3 yrs., D. H. C.
McMahon, H. O.	Detroit, Mich.	24	F. C. House, M. D.	4	2, Westrn. Pa. Col. 2 yrs. D. H. C
Hoffman, W. K., M. D	Bennett, Pa.	25	Dan. Chritsy, M. D	5	4, Clev. Med. College 1 year D. H. C.

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HISTORICAL NOTE

In July, 1843, the *New York Homœopathic Physicians' Society* issued invitations to the homœopathic physicians of the United States to meet in general convention in the city of New York for the purpose of forming a National Homœopathic Medical Society. The invitation was responded to by a considerable number of the leading homœopathic practitioners of the country, who, according to previous arrangement, convened in the Lyceum of Natural History in New York City, on the 10th day of April, 1844, the eighty-ninth anniversary of the birth of the illustrious Hahnemann.

The convention was organized by electing Constantine Hering, M. D., of Philadelphia, Pa., President; Josiah F. Flagg, M. D., of Boston, Mass., and William Channing, M. D., of New York City, N. Y., Vice-Presidents; and Henry Dunnell, M. D., Secretary.

The following resolution was unanimously adopted:

Resolved. That it is deemed expedient to establish a society entitled "*The American Institute of Homœopathy.*"

John F. Gray, M. D., was elected General Secretary of the Institute, and S. R. Kirby, M. D., Treasurer.

The Convention having accomplished the object for which it had assembled, on motion, adjourned, *sine die.*

Immediately after the adjournment of the Convention, on the evening of the 10th day of April, 1844, at the call of John F. Gray, M. D., General Secretary-elect, the First Session of the *American Institute of Homœopathy was held.* Josiah F. Flagg, M. D., Boston, Mass., was elected Chairman, and A. Gerald Hull, M. D., New York City, N. Y., Provisional Secretary.

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CHRONOLOGICAL LIST OF OFFICERS

FIRST SESSION

HELD AT NEW YORK CITY, N. Y., APRIL 10, 1844

JOSIAH F. FLAGG, M. D., Boston, Mass., *Chairman.*
JOHN F. GRAY, M. D., New York, N. Y., *General Secretary.*
A. GERALD HULL, M. D., New York, N. Y., *Provisional Secretary.*
S. R. KIRBY, M. D., New York, N. Y., *Treasurer.*

SECOND SESSION

HELD AT NEW YORK CITY, N. Y., MAY 14, 1845

JACOB JEANES, M. D., Philadelphia, Pa., *Chairman.*
EDWARD BAYARD, M. D., New York, N. Y., *General Secretary.*
R. A. SNOW, M. D., New York, N. Y., *Provisional Secretary.*
S. R. KIRBY, M. D., New York, N. Y., *Treasurer.*

THIRD SESSION

HELD AT PHILADELPHIA, PA., MAY 13, 1846

S. R. KIRBY, M. D., New York, N. Y., *Chairman.*
EDWARD BAYARD, M. D., New York, N. Y., *General Secretary.*
R. A. SNOW, M. D., New York, N. Y., *Provisional Secretary.*
S. R. KIRBY, M. D., New York, N. Y., *Treasurer.*

FOURTH SESSION

HELD AT BOSTON, MASS., JUNE 9, 1847

F. R. McMANUS, M. D., Baltimore, Md., *Chairman.*
EDWARD BAYARD, M. D., New York, N. Y., *General Secretary.*
R. A. SNOW, M. D., New York, N. Y., *Provisional Secretary.*
S. R. KIRBY, M. D., New York, N. Y., *Treasurer.*

FIFTH SESSION

HELD AT NEW YORK CITY, N. Y., JUNE 14, 1848

WALTER WILLIAMSON, M. D., Philadelphia, Pa., *Chairman.*
EDWARD BAYARD, M. D., New York, N. Y., *General Secretary.*
R. A. SNOW, M. D., New York, N. Y., *Provisional Secretary.*
S. R. KIRBY, M. D., New York, N. Y., *Treasurer.*

SIXTH SESSION

HELD AT PHILADELPHIA, PA., JUNE 13, 1849

SAMUEL GREGG, M. D., Boston, Mass., *Chairman.*
ALVIN E. SMALL, M. D., Philadelphia, Pa., *General Secretary.*
WILLIAM P. ESREY, M. D., Springfield, Mass., *Provisional Secretary.*
S. R. KIRBY, M. D., New York, N. Y., *Treasurer.*

SEVENTH SESSION

HELD AT ALBANY, N. Y., JUNE 12, 1850

EDWARD BAYARD, M. D., New York, N. Y., *Chairman.*
ALVIN E. SMALL, M. D., Philadelphia, Pa., *General Secretary.*
G. W. SWAZEY, M. D., Springfield, Mass., *Provisional Secretary.*
S. R. KIRBY, M. D., New York, N. Y., *Treasurer.*

EIGHTH SESSION

HELD AT NEW HAVEN, CONN., JUNE 11, 1851

WILLIAM E. PAYNE, M. D., Bath, Me., *Chairman.*
G. W. SWAZEY, M. D., Springfield, Mass., *General Secretary.*
CHARLES G. FOOTE, M. D., New Haven, Conn., *Provisional Secretary.*
S. R. KIRBY, M. D., New York, N. Y., *Treasurer.*

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NINTH SESSION

HELD AT BALTIMORE, MD., MAY 19, 1852

ELIAL T. FOOTE, M. D., New Haven, Conn., *Chairman.*
WILLIAM A. GARDINER, M. D., Philadelphia, Pa., *General Secretary.*
S. S. GUY, M. D., Brooklyn, N. Y., *Provisional Secretary.*
S. R. KIRBY, M. D., New York, N. Y., *Treasurer.*

TENTH SESSION

HELD AT CLEVELAND, O., JUNE 8, 1853

RICHARD GARDINER, M. D., Philadelphia, Pa., *Chairman.*
WILLIAM A. GARDINER, M. D., Philadelphia, Pa., *General Secretary.*
S. S. GUY, M. D., Brooklyn, N. Y., *Provisional Secretary.*
S. R. KIRBY, M. D., New York, N. Y., *Treasurer.*

ELEVENTH SESSION

HELD AT ALBANY, N. Y., JUNE 7, 1854

LYMAN CLARY, M. D., Syracuse, N. Y., *Chairman.*
S. S. GUY, M. D., Brooklyn, N. Y., *General Secretary.*
J. REDMAN COE, JR., M. D., Philadelphia, Pa., *Provisional Secretary.*
A. S. BALL, M. D., New York, N. Y., *Treasurer.*

TWELFTH SESSION

HELD AT BUFFALO, N. Y., JUNE 6, 1855

C. H. SKIFF, M. D., New Haven, Conn., *Chairman.*
J. P. DRAKE, M. D., Pittsburg, Pa., *General Secretary.*
A. H. BEERS, M. D., Buffalo, N. Y., *Provisional Secretary.*
S. S. GUY, M. D., Brooklyn, N. Y., *Treasurer.*

THIRTEENTH SESSION

HELD AT WASHINGTON, D. C., JUNE 4, 1856

G. W. SWAZEY, M. D., Springfield, Mass., *Chairman.*
F. R. McMANUS, M. D., Baltimore, Md., *General Secretary.*
J. MIDDLETON, M. D., Baltimore, Md., *Provisional Secretary.*
S. S. GUY, M. D., Brooklyn, N. Y., *Treasurer.*

FOURTEENTH SESSION

HELD AT CHICAGO, ILL., JUNE 3, 1857

J. P. DAKE, M. D., Pittsburg, Pa., *Chairman.*
D. S. SMITH, M. D., Chicago, Ill., *General Secretary.*
G. E. SHIPMAN, M. D., Chicago, Ill., *Provisional Secretary.*
S. S. GUY, M. D., Brooklyn, N. Y., *Treasurer.*

FIFTEENTH SESSION

HELD AT BROOKLYN, N. Y., JUNE 2, 1858

D. S. SMITH, M. D., Chicago, Ill., *Chairman.*
WILLIAM E. PAYNE, M. D., Bath, Me., *General Secretary.*
E. T. RICHARDSON, M. D., Brooklyn, N. Y., *Provisional Secretary.*
S. S. GUY, M. D., Brooklyn, N. Y., *Treasurer.*

SIXTEENTH SESSION

HELD AT BOSTON, MASS., JUNE 1, 1859

P. P. WELLS, M. D., Brooklyn, N. Y., *Chairman.*
HENRY D. PAYNE, M. D., Albany, N. Y., *General Secretary.*
I. T. TALBOT, M. D., Boston, Mass., *Provisional Secretary.*
C. H. SKIFF, M. D., New Haven, Conn., *Treasurer.*

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SEVENTEENTH SESSION

HELD AT PHILADELPHIA, PA., JUNE 2, 1860

E. C. WITHERELL, M. D., Cincinnati, O., *Chairman.*
JACOB BEAKLEY, M. D., New York, N. Y., *General Secretary.*
HENRY M. SMITH, M. D., New York, N. Y., *Provisional Secretary.*
C. D. SKIFF, M. D., Brooklyn, N. Y., *Treasurer.*

(No sessions were held during the Civil War.)

EIGHTEENTH SESSION

HELD AT CINCINNATI, OHIO, JUNE 7, 1865

S. S. GUY, M. D., Brooklyn, N. Y., *President.*
I. T. TALBOT, M. D., Boston, Mass., *Vice-President.*
G. D. BEEBE, M. D., Chicago, Ill., *General Secretary.*
WILLIAM TOD HELMUTH, M. D., St. Louis, Mo., *Provisional Secretary.*
D. S. SMITH, M. D., Chicago, Ill., *Treasurer.*

(By a change of the by-laws the Chairman became President, and the office of Vice-President was instituted at this Session.)

NINETEENTH SESSION

HELD AT PITTSBURG, PA., JUNE 6, 1866

J. S. DOUGLAS, M. D., Milwaukee, Wis., *President.*
S. R. BECKWITH, M. D., Cleveland, O., *Vice-President.*
I. T. TALBOT, M. D., Boston, Mass., *General Secretary.*
HENRY B. CLARKE, M. D., New Bedford, Mass., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

TWENTIETH SESSION

HELD AT NEW YORK CITY, N. Y., JUNE 4, 1867

WILLIAM TOD HELMUTH, M. D., St. Louis, Mo., *President.*
P. P. WELLS, M. D., Brooklyn, N. Y., *Vice-President.*
I. T. TALBOT, M. D., Boston, Mass., *General Secretary.*
HORACE M. PAINE, M. D., Albany, N. Y., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

TWENTY-FIRST SESSION

HELD AT ST. LOUIS, MO., JUNE 2, 1868

HENRY D. PAINE, M. D., New York, N. Y., *President.*
T. G. COMSTOCK, M. D., St. Louis, Mo., *Vice-President.*
I. T. TALBOT, M. D., Boston, Mass., *General Secretary.*
H. L. CHASE, M. D., Cambridge, Mass., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

TWENTY-SECOND SESSION

HELD AT BOSTON, MASS., JUNE 8, 1869

REUBEN LUDLAM, M. D., Chicago, Ill., *President.*
D. H. BECKWITH, M. D., Cleveland, O., *Vice-President.*
I. T. TALBOT, M. D., Boston, Mass., *General Secretary.*
TIMOTHY F. ALLEN, M. D., New York, N. Y., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

TWENTY-THIRD SESSION

HELD AT CHICAGO, ILL., JUNE 7, 1870

DAVID THAYER, M. D., Boston, Mass., *President.*
J. J. YOULIN, M. D., Jersey City, N. J., *Vice-President.*
REUBEN LUDLAM, M. D., Chicago, Ill., *General Secretary.*
T. C. DUNCAN, M. D., Chicago, Ill., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

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TWENTY-FOURTH SESSION

HELD AT PHILADELPHIA, PA., JUNE 6, 1871

D. H. BECKWITH, M. D., Cleveland, O., *President.*
J. D. TEMPLE, M. D., St. Louis, Mo., *Vice-President.*
REUBEN LUDLAM, M. D., Chicago, Ill., *General Secretary.*
T. C. DUNCAN, M. D., Chicago, Ill., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

TWENTY-FIFTH SESSION

HELD AT WASHINGTON, D. C., JUNE 21, 1872

I. T. TALBOT, M. D., Boston, Mass., *President.*
J. J. YOULIN, M. D., Jersey City, N. J., *Vice-President.*
ROBERT J. McCLATCHEY, M. D., Philadelphia, Pa., *General Secretary.*
BUSHROD W. JAMES, M. D., Philadelphia, Pa., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

TWENTY-SIXTH SESSION

HELD AT CLEVELAND, OHIO, JUNE 3, 1873

ALVIN E. SMALL, M. D., Chicago, Ill., *President.*
J. C. BURGHER, M. D., Pittsburg, Pa., *Vice-President.*
ROBERT J. McCLATCHEY, M. D., Philadelphia, Pa., *General Secretary.*
BUSHROD W. JAMES, M. D., Philadelphia, Pa., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

TWENTY-SEVENTH SESSION

HELD AT NIAGARA FALLS, N. Y., JUNE 9, 1874

JOHN J. YOULIN, M. D., Jersey City, N. J., *President.*
N. SCHNEIDER, M. D., Cleveland, O., *Vice-President.*
ROBERT J. McCLATCHEY, M. D., Philadelphia, Pa., *General Secretary.*
BUSHROD W. JAMES, M. D., Philadelphia, Pa., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

TWENTY-EIGHTH SESSION

HELD AT PUT-IN-BAY, OHIO, JUNE 16, 1875

WILLIAM H. HOLCOMBE, M. D., New Orleans, La., *President.*
L. E. OBER, M. D., La Crosse, Wis., *Vice-President.*
ROBERT J. McCLATCHEY, M. D., Philadelphia, Pa., *General Secretary.*
BUSHROD W. JAMES, M. D., Philadelphia, Pa., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

TWENTY-NINTH SESSION

HELD AT PHILADELPHIA, PA., JUNE 26 TO JULY 1, 1876, IN CONJUNCTION WITH THE WORLD'S HOMOEOPATHIC CONVENTION; THE OFFICERS OF THE INSTITUTE BEING CONSTITUTED THE OFFICERS OF THE CONVENTION.

CARROLL DUNHAM, M. D., Irvington-on-Hudson, N. Y., *President.*
E. C. FRANKLIN, M. D., St. Louis, Mo., *Vice-President.*
ROBERT J. McCLATCHEY, M. D., Philadelphia, Pa., *General Secretary.*
T. C. DUNCAN, M. D., Chicago, Ill., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

THIRTIETH SESSION

HELD AT LAKE CHAUTAUQUA, N. Y., JUNE 26, 1877

E. C. FRANKLIN, M. D., St. Louis, Mo., *President.*
T. P. WILSON, M. D., Cincinnati, O., *Vice-President.*
ROBERT J. McCLATCHEY, M. D., Philadelphia, Pa., *General Secretary.*
JOSEPH C. GUERNSEY, M. D., Philadelphia, Pa., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

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THIRTY-FIRST SESSION

HELD AT PUT-IN-BAY, OHIO, JUNE 18, 1878

JOHN C. BURGHER, M. D., Pittsburg, Pa., *President.*
J. C. SANDERS, M. D., Cleveland, O., *Vice-President.*
ROBERT J. McCLATCHEY, M. D., Philadelphia, Pa., *General Secretary.*
JOSEPH C. GUERNSEY, M. D., Philadelphia, Pa., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

THIRTY-SECOND SESSION

HELD AT LAKE GEORGE, N. Y., JUNE 17, 1879

CONRAD WESSELHOEFT, M. D., Boston, Mass., *President.*
N. FRANCIS COOKE, M. D., Chicago, Ill., *Vice-President.*
ROBERT J. McCLATCHEY, M. D., Philadelphia, Pa., *General Secretary.*
JOSEPH C. GUERNSEY, M. D., Philadelphia, Pa., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

THIRTY-THIRD SESSION

HELD AT MILWAUKEE, WIS., JUNE 18, 1880

T. P. WILSON, M. D., Ann Arbor, Mich., *President.*
GEORGE A. HALL, M. D., Chicago, Ill., *Vice-President.*
J. C. BURGHER, M. D., Pittsburg, Pa., *General Secretary.*
J. H. McCLELLAND, M. D., Pittsburg, Pa., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

THIRTY-FOURTH SESSION

HELD AT BRIGHTON BEACH, N. Y., JUNE 14, 1881

J. W. DOWLING, M. D., New York, N. Y., *President.*
W. H. BREYFOGLE, M. D., Louisville, Ky., *Vice-President.*
J. C. BURGHER, M. D., Pittsburg, Pa., *General Secretary.*
J. H. McCLELLAND, M. D., Pittsburg, Pa., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

THIRTY-FIFTH SESSION

HELD AT INDIANAPOLIS, IND., JUNE 13, 1882

W. L. BREYFOGLE, M. D., Louisville, Ky., *President.*
BUSHFORD W. JAMES, M. D., Philadelphia, Pa., *Vice-President.*
J. C. BURGHER, M. D., Pittsburg, Pa., *General Secretary.*
JOSEPH C. GUERNSEY, M. D., Philadelphia, Pa., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

THIRTY-SIXTH SESSION

HELD AT NIAGARA FALLS, N. Y., JUNE 19, 1883

BUSHROD W. JAMES, M. D., Philadelphia, Pa., *President.*
O. S. RUNNELS, M. D., Indianapolis, Ind., *Vice-President.*
J. C. BURGHER, M. D., Pittsburg, Pa., *General Secretary.*
T. M. STRONG, M. D., Ward's Island, N. Y., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

THIRTY-SEVENTH SESSION

HELD IN DEER PARK, MD., JUNE 17, 1884

JOHN C. SANDERS, M. D., Cleveland, O., *President.*
T. F. ALLEN, M. D., New York, N. Y., *Vice-President.*
J. C. BURGHER, M. D., Pittsburg, Pa., *General Secretary.*
T. M. STRONG, M. D., Ward's Island, N. Y., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

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THIRTY-EIGHTH SESSION

HELD AT ST. LOUIS, MO., JUNE 2, 1885

TIMOTHY F. ALLEN, M. D., New York, N. Y., *President.*
A. C. COWPERTHWAITE, M. D., Iowa City, Ia., *Vice-President.*
J. C. BURGHER, M. D., Pittsburg, Pa., *General Secretary.*
T. M. STRONG, M. D., Ward's Island, N. Y., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

THIRTY-NINTH SESSION

HELD AT SARATOGA SPRINGS, N. Y., JUNE 28, 1886.

O. S. RUNNELS, M. D., Indianapolis, Ind., *President.*
A. I. SAWYER, M. D., Monroe, Mich., *Vice-President.*
J. C. BURGHER, M. D., Pittsburg, Pa., *General Secretary.*
T. M. STRONG, M. D., Ward's Island, N. Y., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

FORTIETH SESSION

HELD AT SARATOGA SPRINGS, N. Y., JUNE 27, 1887

F. H. ORME, M. D., Atlanta, Ga., *President.*
A. R. WRIGHT, M. D., Buffalo, N. Y., *Vice-President.*
J. C. BURGHER, M. D., Pittsburg, Pa., *General Secretary.*
T. M. STRONG, M. D., Ward's Island, N. Y., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

FORTY-FIRST SESSION.

HELD AT NIAGARA FALLS, N. Y., JUNE 29, 1888

A. C. COWPERTHWAITE, M. D., Iowa City, Ia., *President.*
N. SCHNEIDER, M. D., Cleveland, O., *Vice-President.*
PEMBERTON DUDLEY, M. D., Philadelphia, Pa., *General Secretary.*
T. M. STRONG, M. D., Ward's Island, N. Y., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

FORTY-SECOND SESSION

HELD AT MINNETONKA BEACH, MINN., JUNE 24, 1889

SELDON H. TALCOTT, M. D., Middletown, N. Y., *President.*
THEO. Y. KINNE, M. D., Paterson, N. J., *Vice-President.*
PEMBERTON DUDLEY, M. D., Philadelphia, Pa., *General Secretary.*
T. M. STRONG, M. D., Ward's Island, N. Y., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

FORTY-THIRD SESSION

HELD AT WAUKESHA, WIS., JUNE 16, 1890

ALFRED I. SAWYER, M. D., Monroe, Mich., *President.*
J. D. BUCK, M. D., Cincinnati, O., *Acting President.*
CHESTER G. HIGBEE, M. D. St. Paul, Minn., *Vice-President.*
PEMBERTON DUDLEY, M. D., Philadelphia, Pa., *General Secretary.*
T. M. STRONG, M. D., Macon, Ga., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

[NOTE.—The appointment of an Acting President was made necessary by the illness of the President and the absence of the Vice-President.]

FORTY-FOURTH SESSION

HELD AT ATLANTIC CITY, N. J., IN CONJUNCTION WITH THE FOURTH INTERNATIONAL HOMOEOPATHIC CONGRESS, JUNE 16, 1891

THEO. Y. KINNE, M. D., Paterson, N. J., *President.*
JAMES H. McCLELLAND, Pittsburg, Pa., *Vice-President.*
PEMBERTON DUDLEY, M. D., Philadelphia, Pa., *General Secretary.*
T. M. STRONG, M. D., Macon, Ga., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*
T. FRANKLIN SMITH, M. D., New York, N. Y., *Assistant Treasurer.*

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FORTY-FIFTH SESSION

HELD AT WASHINGTON, D. C., JUNE 13, 1892

THEO. Y. KINNE, M. D., Paterson, N. J., *President.*
JAMES H. McCLELLAND, Pittsburg, Pa., *Vice-President.*
PEMBERTON DUDLEY, M. D., Philadelphia, Pa., *General Secretary.*
T. M. STRONG, M. D., Boston, Mass., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*

FORTY-SIXTH SESSION

HELD AT CHICAGO, ILL., 1893

JAMES H. McCLELLAND, M. D., Pittsburg, Pa., *President.*
C. E. FISHER, M. D., Chicago, Ill., *First Vice-President.*
MILLIE J. CHAPMAN, M. D., Pittsburg, Pa., *Second Vice-President.*
PEMBERTON DUDLEY, M. D., Philadelphia, Pa., *General Secretary.*
T. M. STRONG, M. D., Boston, Mass., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*
T. FRANKLIN SMITH, M. D., New York, N. Y., *Assistant Treasurer.*

FORTY-SEVENTH SESSION

(FIFTIETH ANNIVERSARY)

HELD AT DENVER, COL., 1894

JAMES H. McCLELLAND, M. D., Pittsburg, Pa., *President.*
C. E. FISHER, M. D., Chicago, Ill., *First Vice-President.*
MILLIE J. CHAPMAN, M. D., Pittsburg, Pa., *Second Vice-President.*
PEMBERTON DUDLEY, M. D., Philadelphia, Pa., *General Secretary.*
T. M. STRONG, M. D., Boston, Mass., *Provisional Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*
T. FRANKLIN SMITH, M. D., New York, N. Y., *Assistant Treasurer.*

FIFTY-FIRST SESSION

HELD AT NEWPORT, R. I., 1895.

CHARLES E. FISHER, M. D., Chicago, Ill., *President.*
J. B. GREGG CUSTIS, M. D., Washington, D. C., *First Vice-President.*
EUGENE F. STORKE, M. D., Denver, Col., *Second Vice-President.*
EUGENE H. PORTER, M. D., New York, N. Y., *General Secretary.*
FRANK KRAFT, M. D., Cleveland, O., *Recording Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*
T. FRANKLIN SMITH, M. D., New York, N. Y., *Assistant Treasurer.*

FIFTY-SECOND SESSION

HELD AT DETROIT, MICH., 1896

PEMBERTON DUDLEY, M. D., Philadelphia, Pa., *President.*
D. A. MACLACHLAN, M. D., Detroit, Mich., *First Vice-President.*
J. C. BUDLONG, M. D., Providence, R. I., *Second Vice-President.*
EUGENE H. PORTER, M. D., New York, N. Y., *General Secretary.*
FRANK KRAFT, M. D., Cleveland, O., *Recording Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*
T. FRANKLIN SMITH, M. D., New York, N. Y., *Assistant Treasurer.*

FIFTY-THIRD SESSION

HELD AT BUFFALO, N. Y., 1897

J. B. GREGG CUSTIS, M. D., Washington, D. C., *President.*
CHAS. E. WALTON, M. D., Cincinnati, O., *First Vice-President.*
C. C. MILLER, M. D., Detroit, Mich., *Second Vice-President.*
EUGENE H. PORTER, M. D., New York, N. Y., *General Secretary.*
FRANK KRAFT, M. D., Cleveland, O., *Recording Secretary.*
E. M. KELLOGG, M. D., New York, N. Y., *Treasurer.*
T. FRANKLIN SMITH, M. D., New York, N. Y., *Assistant Treasurer.*

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FIFTY-FOURTH SESSION

HELD AT OMAHA, NEB., 1898

A. R. WRIGHT, M. D., Buffalo, N. Y., *President*
WM. E. GREEN, M. D., Little Rock, Ark., *First Vice-President.*
CH. GATCHELL, M. D., Chicago, Ill., *Second Vice-President.*
EUGENE H. PORTER, M. D., New York, N. Y., *General Secretary.*
FRANK KRAFT, M. D., Cleveland, O., *Recording Secretary.*
E. M. KELLOGG, 115 37th St., New York, N. Y., *Treasurer.*
T. FRANKLIN SMITH, M. D., New York, *Assistant Treasurer.*

FIFTY-FIFTH SESSION

HELD AT ATLANTIC CITY, N. J., 1899

BENJ. F. BAILEY, M. D., Lincoln, Neb., *President.*
A. B. NORTON, M. D., New York, *First Vice-President.*
SARAH J. MILLSOP, M. D., Bowling Green, Ky., *Second Vice-President.*
EUGENE H. PORTER M. D., New York, *General Secretary.*
FRANK KRAFT, M. D., Cleveland, O., *Recording Secretary.*
E. M. KELLOGG, M. D., 115 E. 37th St., New York, N. Y., *Treasurer.*
T. FRANKLIN SMITH, M. D., New York, *Assistant Treasurer.*

FIFTY-SIXTH SESSION

HELD AT WASHINGTON, D. C., 1900

CHAS. E. WALTON, M. D., Cincinnati, O., *President.*
JOSEPH P. COBB, M. D., Chicago, Ill., *First Vice-President.*
NANCY T. WILLIAMS, M. D., Augusta, Me., *Second Vice-President.*
EUGENE H. PORTER, M. D., New York, N. Y., *General Secretary.*
WILSON A. SMITH, M. D., Morgan Park, Ill., *Recording Secretary.*
T. FRANKLIN SMITH, M. D., New York, N. Y., *Treasurer.*

FIFTY-SEVENTH SESSION

HELD AT RICHFIELD SPRINGS, N. Y., 1901

A. B. NORTON, M. D., New York, N. Y., *President.*
GEO. ROYAL, M. D., Des Moines, Ia., *First Vice-President.*
FLORENCE N. WARD, M. D., San Francisco, Cal., *Second Vice-President.*
EUGENE H. PORTER, M. D., New York, N. Y., *General Secretary.*
T. FRANKLIN SMITH, M. D., 264 Lenox ave., New York, N. Y., *Treasurer.*
WILSON A. SMITH, M. D., Morgan Park, Ill., *Recording Secretary.*

FIFTY-EIGHTH SESSION

HELD AT CLEVELAND, O., JUNE 17, 1902

JAMES C. WOOD, A. M., M. D., Cleveland, O., *President.*
EDWARD BEECHER HOOKER, M. D., Hartford, Conn., *First Vice-Pres.*
EDWARD Z. COLE, M. D., Baltimore, Md., *Second Vice-President.*
CH. GATCHELL, M. D., Chicago, *General Secretary.*
T. FRANKLIN SMITH, M. D., New York, N. Y., *Treasurer.*
WILSON A. SMITH, M. D., Morgan Park, Ill., *Recording Secretary.*

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CONSTITUTION AND BY-LAWS

CONSTITUTION

ADOPTED JUNE 19, 1902

ARTICLE I.—*Name and Object.*

This association shall be styled the American Institute of Homœopathy, and its object the improvement of Homœopathic therapeutics and all other departments of medical science.

ARTICLE II.—*Members.*

The Institute shall consist of a central body and sectional societies whose members shall also be members of the Institute.

ARTICLE III.—*Officers.*

The Officers of the Institute shall be a President, two Vice-Presidents, who shall be designated First and Second; a Secretary, a Treasurer and a Registrar, with such other officers as shall be designated by the by-laws, to be chosen at such time, in such manner, for such period, and with such duties as the by-laws shall ordain.

ARTICLE IV.—*Seal.*

The Institute shall have and use one common seal, with a suitable device and inscription.

ARTICLE V.—*Amendments.*

This Constitution may be altered or amended by a vote of two-thirds of all members present at the regular annual meeting, provided that notice of such alteration or amendment shall have been given in writing at any meeting of a previous annual session of the Institute.

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BY-LAWS

ADOPTED JUNE 19, 1902

ARTICLE I.—*Meetings.*

This Institute shall hold at least one session in each year, at such time and place as may be determined upon from time to time.

ARTICLE II—*Officers.*

SECTION 1. The officers shall be elected by ballot at each annual session of the Institute, and shall enter upon their respective duties at the close of the session at which they are elected, excepting the Secretary, whose term of office shall expire upon the first day of January following.

SECTION 2. The officers of the Institute, viz., the President, Vice-Presidents, Secretary, Treasurer, and Registrar, shall constitute an Executive Committee, which shall arrange the business of the session, attend to matters of business not otherwise especially provided for, and perform such other duties as may by vote of the Institute devolve upon them. They shall have power to fill any vacancies occurring in the election of officers.

SECTION 3. The Secretary shall be paid an annual salary of $1,000.

ARTICLE III.—*Duties of Officers.*

SECTION 1. The President shall preside at the meetings of the Institute and perform the duties usually pertaining to his office, together with such other duties as may by vote of the Institute devolve upon him. He shall sign all certificates of membership. He shall deliver an address at the opening of each session, and make such suggestions as he may deem necessary for the Institute to take action on during the session; and he may also consider any subject relating to medical science.

SECTION 2. The Vice-Presidents in their order shall perform the duties of the President in his absence or disability.

SECTION 3. The Secretary shall keep a record of the proceedings of the meetings, conduct the correspondence of the Institute, issue notices of meetings, notify members of their election, sign certificates, and perform such other duties as the Institute may direct. It shall further be the duty of the Secretary to send to each Homœopathic jour-

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nal published in the country, within two weeks after the adjournment of the annual meeting, a list of the officers for the ensuing year, together with the officers of the Sectional Societies.

SECTION 4. It shall be the special duty of the Secretary to make or provide stenographic reports of all scientific discussions of the Institute and of its bureaus, and of all Standing Committees. He shall send copies of these scientific discussions for revision and correction to their authors, respectively, who shall be required to return them within one week after their reception for publication in the Transactions. If not so returned the original record shall be used by the Secretary. The compensation and necessary expenses connected with such reports shall be paid by the Institute upon presentation and approval of the certified accounts.

SECTION 5. The Treasurer shall receive all money belonging to the Institute, and make all disbursements under the recommendation of the Executive Committee. He shall furnish at each annual meeting a written report of the condition of the finances.

SECTION 6. The Registrar shall attend to the registration of members present at the annual sessions, the preparation of a daily roster, and the distribution of the appropriate badges to members and visitors. He shall make a full report to the Secretary at the close of the annual meeting.

ARTICLE IV.—*Censors.*

SECTION 1. There shall be a Board of Censors, consisting of five members (three of which shall constitute a quorum), who shall receive and examine the credentials of candidates for membership, and report to the Institute for election such as may be found properly qualified. One member of said Board shall be elected by ballot at each annual session, to serve for five years from the first day of January next succeeding said election.

ARTICLE V.—*Membership.*

SECTION 1. Candidates for membership shall present to the Board of Censors a certificate of three members of the Institute that the applicant has pursued a regular course of medical studies according to the requirements of the existing institutions of this country, and sustains a good moral character and professional standing. Such certificate shall state when and where the applicant obtained a diploma. If found qualified, the candidate may be elected a member, provided the name of said candidate shall have been presented by the Board of Censors before the last day of the regular session. No person shall be considered a member,

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however, before paying an admission fee of two dollars, and the annual dues, which shall entitle him to a certificate of membership.

SECTION 2. No physician, graduate subsequent to the year 1891, shall be eligible to membership, unless said graduation has followed three full annual courses of didactic and clinical lectures of not less than six months each.

SECTION 3. Members shall pay annually the sum of five dollars toward defraying the expenses of the Institute. The Transactions of the Institute shall be sent to those members only who have paid their dues.

SECTION 4. Members neglecting the payment of dues for three years, after proper notification from the Treasurer, shall have their names dropped from the roll of membership. Any person thus dropped shall have the privilege of reinstatement by paying all arrearages, on recommendation of the Board of Censors.

SECTION 5. The Executive Committee shall be authorized to remit, *sub silentia,* the dues of those who, for ten years, have been in good membership and have paid their dues during that time, provided that such members are unable to continue the payment of their annual dues.

SECTION 6. All members of the Institute who have maintained twenty-five consecutive years of membership shall be considered Senior Members, and be exempt from the payment of annual dues; and the names of such members shall be printed first in the list of members, in capital letters.

SECTION 7. Any foreign physician may be elected a Corresponding Member of the Institute at any annual meeting, on recommendation of the Board of Censors, and shall have all the privileges of members, except voting and eligibility to office.

SECTION 8. The Institute may at any annual meeting elect as Honorary Members, not to exceed five in one year, any foreign physicians who may be judged worthy from their superior attainments in medicine; provided, that the names of persons proposed for Honorary Membership shall have been presented at a previous annual meeting. Such Honorary Members shall have all the privileges of members except voting and eligibility to office.

SECTION 9. The Institute may, at any annual meeting, elect as Honorary Associate Members, not to exceed three in one year, any persons not members of the medical profession, who have been in any way of special service to science and humanity, and particularly those who

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have been special patrons of homœopathy, and said Honorary Associate Members shall have all the privileges of Honorary Members.

SECTION 10. Any physician properly accredited as a delegate shall be admitted during the session of the Institute to all the privileges of members, except voting and eligibility to office, on the following basis:

First.—From every association composed of more than fifty members from different States, two delegates, with an additional delegate for every twenty members.

Second.—From every State society, two delegates, with an additional delegate for every twenty members.

Third.—From every country or local society, one delegate.

Fourth.—From every hospital, asylum for the insane, or dispensary actually established, one delegate.

Fifth.—From every medical journal established, one delegate.

Sixth.—From every college associated with the Institute, two delegates; said delegates to constitute the Intercollegiate Committee of the Institute.

ARTICLE VI.—*Bureaus.*

SECTION 1. The following bureaus shall be appointed as hereinafter provided for:

A—Materia Medica and General Therapeutics.

B—Clinical Medicine and Pathology.

C—Homœopathy.

D—Pedology.

E—Sanitary Science and Public Health.

SECTION 2. Each of these bureaus shall consist of not less than five members.

SECTION 3. The chairman of each bureau, as soon as possible after appointment, shall select his associates and complete the organization of his bureau by the appointment of a secretary. He shall, within one month after his appointment, send to the Secretary a list of the officers and members of his bureau. In case of failure to comply with the provisions of this section the President is authorized to appoint another chairman. And the presidents of the sectional societies shall also conform to the requirement laid upon the chairmen of bureaus, in matter of making report to the Secretary.

SECTION 4. No member shall be appointed to more than one bureau in one year. If any member's name occurs in more than one bureau he shall be notified by the Secretary to elect the one to which he wishes to be assigned. No chairman shall serve as such two successive years.

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SECTION 5. Vacancies occurring in any bureau may be filled by the chairman, who shall give immediate notice thereof to the Secretary.

SECTION 6. The Institute shall recognize the following Sectional Societies as parts of its body:

(a) The Surgical and Gynecological Society of the American Institute of Homœopathy.

(b) The Ophthalmological, Otological and Laryngological Society of the American Institute of Homœopathy.

(c) The Obstetrical Society of the American Institute of Homœopathy.

(d) The Electro-Therapeutical Society of the American Institute of Homœopathy; and such other Societies as may be formed from time to time, under the rules and regulations of the Institute.

SECTION 7. Each Sectional Society shall perfect its own organization, make its own constitution and by-laws, elect its own officers and conduct its own deliberations. It shall have self-government so far as its organization and conduct of its affairs is concerned, but shall be strictly under the rule of the Institute in all matters of publication and other requirements of general welfare.

SECTION 8. The meetings of the Sectional Societies shall be held annually at the same place and time as the Institute, but shall not conflict with the sessions of the Institute except as permitted by the Executive Committee of the Institute.

SECTION 9. The President of each Sectional Society shall present to the general session, from time to time, such matters as may be of general interest to the profession.

SECTION 10. No constitution or by-law of any Sectional Society shall in any manner conflict with the constitution or by-laws of the Institute.

ARTICLE VII.—*Committees.*

SECTION 1. (a) Organization, Registration and Statistics.

(b) International State Committee.

(c) International Bureau of Homœopathy.

(d) Intercollegiate.

(e) Drug Provings.

(f) Committee on Medical Examining Boards and Medical Legislation.

SECTION 2. Committee "B" shall consist of two members from each State, to be appointed by the respective State societies, provided such

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appointees are members of the Institute; the Chairman shall be elected by the committee.

Committee "D" shall consist of two delegates to be appointed by each College represented in the Institute, and shall appoint its own Chairman.

Committee "E" shall consist of five members, one to be appointed each year, and the term of service of each member in this committee to be five years.

The remaining standing committees shall consist of at least five members each, who shall serve for one year.

SECTION 3. There shall also be appointed each year Committees on Local Arrangements, on Transportation, on Press, on Resolutions and Business, and on the Memorial Service, of not less than three members each. The duties of said committees shall be such as are indicated by their respective titles. All resolutions presented to the Institute shall be referred without debate to the Committee on Resolutions, except those resolutions emanating from standing committees.

SECTION 4. The President, so far as these by-laws require, shall appoint each of the committees provided for in this article.

SECTION 5. All committees or members appointed to perform any special work under the authority of this Institute shall serve without compensation, unless otherwise specifically ordered.

SECTION 6. The President shall have the power to fill any vacancies that may occur in any committee during or between the sessions of the Institute. Vacancies and elective offices may be filled by nomination and election in open meeting during any session of the Institute, the members-elect to hold such office until the arrival of the regular occupant. The Executive Committee may, at any time when deemed necessary, fill any vacancy occurring in an elective office between the sessions of the Institute, such appointee to hold office until the opening of the next regular session. Absence from the session of the Institute shall constitute a vacancy.

ARTICLE VIII.—*Committee on Publication.*

SECTION 1. The Committee on Publication shall consist of three members of the Institute, to be appointed annually by the Executive Committee, whose duty shall be to pass upon all papers or reports presented to the Institute, and the decision of such Committee as to the publication of papers or reports shall be final.

SECTION 2. No report or paper referred to the Committee on Publication shall be rejected except with the formal concurrence of a ma-

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jority of said Committee. All papers so rejected shall be returned to their authors by the Secretary.

SECTION 3. The Transactions of the Institute shall be issued by the Secretary, under the direction of the Committee on Publication, within five months after the close of the session, and copies shall be delivered to those entitled to them, without individual expense.

SECTION 4. There shall be published in each annual volume of the Transactions: 1. A list of senior members arranged according to their years of membership. 2. An alphabetical list of members, including the names of senior members in Capitals. 3. A list of members classified by States. The complete list of members of the Institute from its organization, and its Code of Ethics, shall be published every five years.

SECTION 5. The Secretary shall furnish editorial copies of the Transactions to such Homœopathic journals as are sent to the Institute in exchange, and to other selected journals.

SECTION 6. The Secretary shall send copies of the Statistical Reports to all societies, hospitals, and dispensaries that make reports to the Committee on Organization, Registration and Statistics.

ARTICLE IX.—*Rules of Order.*

SECTION 1. The names and residences of all applicants for membership shall be announced in alphabetical order by the Board of Censors in open session, at least six hours before their election is voted upon.

SECTION 2. The Report of the Necrologist shall be presented in connection with the Report of the Committee on Memorial Service.

SECTION 3. The time allotted to any committee for the presentation of its report shall not exceed fifteen minutes. No report shall be received from any Committee except in writing.

SECTION 4. No report or paper shall be received by the Institute in an incomplete or unfinished condition, and no paper shall be published in the Transactions which has been published previous to its presentation to the Institute, or which is not handed to the Secretary before the close of the session.

SECTION 5. Meetings of the bureaus may be held at the call of its Chairman, provided such meetings be not held during the sittings of the Institute, nor during the meetings of the other bureaus, except as provided in the adopted Order of Business.

SECTION 6. In all discussions no speaker shall be allowed more than

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five minutes, nor to speak more than once upon the same subject, except by vote of consent taken in the usual manner.

SECTION 7. At the conclusion of the work of each bureau its Chairman shall hand to the Secretary its reports, addresses, and papers, which shall remain in his hands until the Transactions are printed.

SECTION 8. The election of officers for the ensuing year shall take place on the second morning of the session, at 10 a. m., Sunday excepted. The nominations shall be made on the first morning of the session, at 10 a. m., in the following way: Nomination papers shall be furnished by the Secretary on the first day of the session, and any person receiving the indorsement of ten members shall be considered a nominee, provided no indorser's name appear on more than one paper for that office. If no nomination papers are handed in, it shall be the duty of the Executive Committee to see that at least one paper shall be prepared for each of the elective officers. No nomination shall be considered after the President has declared the nominations closed. These papers shall immediately be placed in charge of a special committee of three, to be appointed by the President, to which shall be added the Treasurer and Registrar, *ex officio*. The duties of the committee shall be, first, to prepare an official ballot, on which the names of all nominees shall be placed in alphabetical order for the office to which they are nominated. Second, to take general charge of the election, which shall occur on the second morning of the Institute session, excepting Sunday, at 10 a. m., the polls to be open two hours, and in such manner as not to interfere with the general work of the session. Third, in conjunction with the Secretary and Treasurer, to prepare a roster of members in good standing, which shall be used as a check list and ultimate judge as to voting and qualifications of members. Upon declaration of the result, should no election be had for any office, the Institute shall, in open session, elect from two candidates receiving the highest number of votes which person it prefers. Members shall vote by the method known as the Australian system, *i. e.*, putting a cross-mark opposite the name of the person voted for. Should more marks be placed than the office calls for, such ballot shall be invalidated, so far as that particular office is concerned. The inspectors of election shall report when and as the Institute may direct.

SECTION 9. The determination of the next place of meeting shall take place as follows: All invitations for places of meeting shall be forwarded to the Executive Committee at least ninety days before the date of the annual session, whereupon the Committee shall investigate the various places, with reference to accommodations, hotel-rates, railroad

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facilities, and obtain all necessary information. The Committee's report shall be made to the Institute, when the location shall be determined.

Article X.

All complaints relating to violations of the Code of Ethics for the Institute shall be referred to the Senate of Seniors for consideration and adjustment, and its decision shall be final, without further action of the Institute; except in such cases as require disciplinary action, when the Senate shall report to the Institute with recommendations.

Questions in dispute, having a bearing upon the general good of Homœopathy, which may be brought before the Institute for review and judgment, shall be referred to the Senate of Seniors for adjustment. In order to appeal from its decison a two-thirds vote of members present and voting shall be necessary, said vote to be had without debate; all appeals thus ordered shall be heard at a special hour set for the purpose, and shall be considered in Executive Session.

Article XI.—*Amendments.*

These By-Laws may be altered or amended by a vote of two-thirds of the members present at any session of the annual meeting, provided that notice of such alteration or amendment shall have been given at the previous annual meeting. They may be suspended at any session of the annual meeting by a two-thirds vote of the members present.

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STANDING RESOLUTIONS

1. *Resolved,* That the American Institute of Homœopathy does not necessarily indorse the doctrine contained in the reports of committees by accepting and publishing such reports with the Proceedings. *Adopted June 4, 1867.*

2. *Resolved,* That this Institute condemns the action of any college which graduates an unsuccessful candidate from another college, unless he attends at least one full course of lectures at the college where he applies for a degree. *Adopted June 30, 1886.*

3. *Resolved,* That the Committee on Local Arrangements be instructed to respect the working hours of the Institute session, and to make no provision for entertainments to the members except during the intermission of the session. *Adopted June 20, 1890.*

4. *Resolved,* That beginning with the session of 1895-96 all colleges recognized by the Intercollegiate Committee of the American Institute of Homœopathy shall require attendance on four courses of lectures of not less than six months each, in separate years. *Adopted June 20, 1894.*

5. *Resolved,* That while the Intercollegiate Committee of the American Institute of Homœopathy would regard with favor any movement looking to the establishment of chairs of Homœopathic Therapeutics or Materia Medica in any college or university in which such chairs do not now exist, it would most unqualifiedly condemn any movement to transfer any existing Homœopathic institution to any old-school college in a manner which involves the surrender of its distinctive name, and under conditions which do not secure the recognition of distinctive chairs of Homœopathy. *Adopted June 20, 1894.*

6. *Resolved,* That the Executive Committee of the American Institute of Homœopathy be the Committee of Arrangements, with a local auxiliary committee, in order that the officers of the Institute may control the important matters connected with the meeting. *Adopted June 2, 1898.*

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CODE OF MEDICAL ETHICS

OF THE

AMERICAN

INSTITUTE OF HOMŒOPATHY

(ADOPTED IN 1883)

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CODE OF MEDICAL ETHICS

SCOPE

THE scope of a Code of Medical Ethics comprises the reciprocal duties and obligations of physicians and patients; the duties and obligatons of physicians to each other; and the reciprocal duties and obligations of physicians and the public.

FUNDAMENTAL PRINCIPLES

The great principles upon which Medical Ethics are based arc these:

1. The great end and object of the physician's efforts should be: "The greatest good to the patient."

2. The rule of conduct of physician and patient, and of physicians toward each other, should be the GOLDEN RULE: "As ye would that men should do to you, do ye also to them, likewise."

The various articles of the Code are only special applications of these great principles.

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PART I.

RECIPROCAL DUTIES AND OBLIGATIONS OF PHYSICIANS AND PATIENTS.

Article I. Duties of Physicians to Patients.
" II. Duties of Patients to their Physicians.

PART II.

DUTIES AND OBLIGATIONS OF PHYSICIANS TO EACH OTHER.

Article I. Duties as Members of the Medical Profession.
" II. Professional Services to Each Other.
" III. Vicarious Services.
" IV. In Regard to Consultation.
" V. In Cases of Interference.
" VI. Differences Between Physicians.
" VII. Concerning Pecuniary Obligations.

PART III.

RECIPROCAL DUTIES AND OBLIGATIONS OF PHYSICIANS AND THE PUBLIC.

Article I. Duties of the Profession to the Public.
" II. Obligations of the Public to Physicians.

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PART I.

OF THE RECIPROCAL DUTIES AND OBLIGATIONS OF PHYSICIANS AND THEIR PATIENTS.

Article I.—Duties of the Physician to the Patient.

SECTION 1. The physician should hold himself in constant readiness to obey the calls of the sick. He should bear in mind the sacred character of his calling and the great responsibility which it involves, and should remember that the comfort, the health and the lives of his patients depend upon the skill, attention and faithfulness with which he performs his professional duties.

SECTION 2. The physician, in order that he may be able to exercise his vocation to the best advantage of the patient, should possess his respect and confidence. These must be acquired and retained by faithful attention to his malady, by indulgent tenderness towards the weaknesses incident to his condition, and by the exercise of a firm but kindly authority. The physician is bound to keep secret whatever he may either hear or observe while in the discharge of his professional duties, respecting the private affairs of the patient or his family. And this obligation is not limited to the period during which the physician is in attendance on the patient. The patient should be made to feel that he has, in his physician, a friend who will guard his secrets with scrupulous honor and fidelity.

SECTION 3. The physician should visit his patient as often as may be necessary to enable him to acquire and keep a full knowledge of the nature, progress, changes and complications of the disease, and to do for the patient the utmost of good that he is able. But he should carefully avoid making unnecessary visits, lest he render the patient needlessly anxious about his case, or expose himself to the charge of being actuated by mercenary motives.

SECTION 4. The physician should not give expression to gloomy forebodings respecting the patient's disease, nor magnify the gravity of the case. Bearing in mind the almost infinite resources of nature, he should be cheerful and hopeful, both in mind and man-

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ner. This will enable him the better to exercise his faculties and apply his knowledge for the patient's benefit, and will inspire the patient with confidence, courage and fortitude, which are the physician's best moral adjuvants.

But it is the physician's duty to state the true nature and prospects of the case, from time to time, to some judicious friend or relative of the patient, and to keep this person fully informed of its changes and probable issue; and if the patient himself request the physician to disclose to him the nature and prognosis of his disease, it is his duty to state tenderly, but frankly, the whole truth,—provided the patient be of sound mind and strong enough to receive the disclosure without serious injury. The patient has a right to know the truth. If, moreover, facts within the physician's knowledge lead him to believe that it is of great importance, in relation to the patient's affairs, that he should be warned of the approach of death, it is the physician's duty to reveal to the patient's nearest friend, or to the patient himself, the true state of the case, and the importance of timely action.

SECTION 5. Whether the case proceed favorably, or become manifestly incurable, it is the physician's duty to continue his attendance faithfully and conscientiously so long as the patient may desire it. He is not justified in abandoning a case merely because he supposes it incurable.

SECTION 6. As the patient has an undoubted right to dismiss his physician for reasons satisfactory to himself, so, likewise, the physician may, with equal propriety, decline to attend patients, when his self-respect or dignity seem to him to require this step; as, for example, when they persistently refuse to comply with his directions.

SECTION 7. In difficult or protracted cases consultations are advisable. They tend to increase the knowledge, energy and confidence of the physician, and to maintain the courage of the patient. The physician should be ready to act upon any desire which the patient may express for a consultation, even though he may not himself feel the need of it. Nothing is so likely to maintain the patient's confidence as alacrity in this respect. Moreover, such a course is but just to him, for he has an indisputable right to whatever aid or counsel he may think likely to be of service to him.

SECTION 8. The intimate relations into which the physician is brought with his patient give him opportunity to exercise a power-

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ful moral influence over him. This should always be exerted to turn him from dangerous or vicious courses towards a temperate and virtuous life. The physician is sometimes called to assist in practices of questionable propriety, and even of a criminal character. Among these may be mentioned the pretence of disease, in order to evade services demanded by law, as jury or military duty; the concealment of organic disease or of morbid tendencies, in order to secure favorable rates of life insurance, or for deception of other kinds; and especially the procurement of abortion when not necessary to save the life of the mother. To all such propositions, the physician should present an inflexible opposition. It is his duty, in an authoritative, but friendly manner, to explain and urge the nature, illegality and guilt of the proposed action, and to use every effort to dissuade from it, and to strengthen the patient's virtue and sense of right. The physician should be aware of the frequency of criminal abortion, and of the different methods employed for it, and should take every occasion to warn those who may be tempted to resort to it. In no case should the physician induce abortion, or premature labor, without a previous consultation with the most experienced practitioners attainable, nor without the most clear and imperative reasons.

Article II.—Duties and Obligations of Patients to their Physicians.

SECTION 1. Physicians are required, by the nature of their profession, to sacrifice comfort, ease and even health, for the sake of their patients. Patients should reflect upon this, and should understand and remember that they have corresponding duties and obligations towards their physicians.

SECTION 2. The patient should select a physician in whose knowledge, skill and fidelity he can place implicit confidence; whose habits of life are regular and temperate, and whose character and demeanor are such that he can regard him as a personal friend. He must be able to confide in him freely. And the physician should not be changed for light reasons. A physician thoroughly acquainted with the constitution, temperament and tendencies of a family can the more successfully treat them.

SECTION 3. The patient should always consult his physician as early as possible after he has discovered that he is ill. A disease which is trifling at its onset may grow formidable through neglect.

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The physician should be regarded as a confidential adviser, who, on being early consulted, may prevent a sickness.

SECTION 4. The patient should faithfully and unreservedly state to his physician the supposed cause of his malady, and tell him everything that may have a bearing upon its nature. Since the physician is under the strongest obligations to secrecy, the patient should not allow considerations of delicacy, modesty or pride to prevent an entirely frank statement of his case, and candid and full replies to interrogatories.

SECTION 5. The patient should implicitly obey his physician's injunctions as regards diet, regimen and medical treatment. If he deviate from these directions, he cannot hold the physician to a full responsibility in the case; and, further, by a partial obedience he incurs some personal risk, since, in the treatment of diseases, all parts of the phyiscian's advice are made to harmonize, and each is dependent on the others and may be unsafe without the coincidence of the others. Moreover, he does the physician an undeserved, and often a serious, wrong. If the patient have not sufficient confidence in his physician, and respect for him, to follow his directions, it were better for him to frankly say so, and to employ another in whom he can confide.

The patient should never allow himself, while under a physician's treatment, to take other medicines than those prescribed by him. He would, by so doing, incur a serious risk of taking medicines that are incompatible with each other. If desirous of trying any other mode of treatment it would be much better frankly to state the fact to his physician and ask his advice.

SECTION 6. The patient should, if possible, avoid receiving the friendly visit of a physician other than the one under whose charge he is. When he receives such visits he should avoid conversation on the subject of his disease, for an accidental observation might give him false impressions respecting his disease or destroy his confidence in the treatment he is pursuing. He should never send for a consulting physician without the express consent of his own medical attendant, for physicians can act together for the advantage of their patient only when they act harmoniously. Nor should he, by a secret appointment, constrain his medical attendant to meet another physician with whom he might not be willing to consult; but the patient has an undoubted right to have the opinion of any physician whom he may desire upon his case. His proper course is to request his medical attendant to

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arrange a consultation and frankly state his desire for the physician whom he may prefer. If his medical attendant decline the consultation it is then for the patient to determine whether he will insist and thus dismiss his medical attendant, or whether he will defer to the judgment of his own physician. And the patient has a right thus to choose.

SECTION 7. If the patient wishes to dismiss his physician he should, in justice and in common courtesy, state his reasons, and, if possible, in a friendly manner. To dispense with the services of a physician need not, of necessity, change the social relations of the parties.

SECTION 8. The patient should, when practicable, send for the physician in the morning, before his usual hour for leaving home. He will, by so doing, secure his earlier attendance, and will enable him the better to apportion his time so as to do justice to all his calls and engagements. He should call on his physician during his office hours only, and should avoid disturbing him in hours devoted to meals, rest and sleep. And in receiving his physician's visits he should avoid compelling him to wait, even a few minutes. The aggregate of petty detentions, while the patient is making some needless preparation to receive the physician, amount to a serious waste of valuable time.

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PART II.

OF THE DUTIES AND OBLIGATIONS OF PHYSICIANS TO THE PROFESSION AND TO EACH OTHER.

Article I.—Duties to the Profession.

SECTION 1. Inasmuch as every member of the medical profession partakes of the honor in which it is held, and is entitled to its privileges and immunities and profits by the scientific labors of his predecessors and associates, it is his duty faithfully to endeavor, in his turn, to elevate the position of the profession and, by every honorable exertion, to enrich the science of medicine.

SECTION 2. In no other profession should a higher standard of morality and greater purity of personal character be required. Physicians ought to come up to this standard and do what they may to exalt it. As the practice of medicine requires constant exercise of a vigorous and clear understanding, and as the practitioner should be, at all times, ready for emergencies in which the welfare and even the life of a fellow-creature may depend upon his steady hand, acute eye and unclouded brain, it is incumbent upon the physician to be temperate in all things.

SECTION 3. The physician should not resort to public advertisements or private cards or handbills, inviting the attention of persons affected by particular diseases or publicly offering advice and medicine to the poor *gratis,* or promising radical cures. Neither should he publish cases or operations in the daily prints, nor invite laymen to be present at operations, nor solicit or exhibit certificates of skill and success, nor perform any similar act.

SECTION 4. It is equally derogatory to professional character for a physician to hold a patent for any nostrum or any surgical instrument or appliance, or to keep secret the nature or composition of any medicine used by him. Such restriction or concealment is inconsistent with the beneficence and liberality which should characterize the medical profession. But it is the duty of the physician to avail himself of every opportunity to observe

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the action and study the properties of new or secret remedies and new processes of preparing medicines as well as new modes of treating diseases, and to subject them to the analysis of scientific investigation. For the physician should always bear in mind that the great object of his profession is to cure the sick, and that it is not only admissible, but is his solemn duty to investigate thoroughly and without prejudice whatever offers any probability of adding to his knowledge of the art and means of curing and of thus enriching the science of medicine.

Article II.—Professional Services of Physicians to each other.

SECTION 1. All practitioners of medicine, their wives and children while under the paternal care, are entitled to the gratuitous services of any one or more of the faculty residing near them. Physicians, when ill, are incompetent to prescribe for themselves. The natural anxiety and solicitude which they feel for members of their own family when ill tend to obscure their professional judgment and make it difficult to treat them. Under these circumstances physicians are peculiarly dependent on each other, and kind offices and professional aid should always be cheerfully and gratuitously afforded. But visits should not be obtruded officiously or unasked upon a sick physician.

If, however, a physician in affluent circumstances, request the attendance of a distant professional brother and offer an *honorarium,* it is not proper to decline it, for one should not, even from a kindly motive, impose upon another a pecuniary obligation which the recipient would not wish to incur.

If a physician is called from any considerable distance the expense of travel, etc., thereby incurred, should always be paid by the physician receiving the visit, and an *honorarium* may be tendered if time is consumed in making the visit.

Article III.—Duties of Physicians as regards Vicarious Offices.

SECTION 1. Attention to his personal affairs, the pursuit of health and the various contingencies to which the physician is peculiarly exposed, sometimes compel him temporarily to withdraw from his duties to his patients and to request some of his professional brethren to discharge them for him. Compliance with such a request is an act of courtesy which should always be performed with the utmost consideration for the interests and

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character of the physician relieved. And when this is done for a short period only all the pecuniary obligations for such services should belong to him. But if a physician neglect his business in quest of amusement and pleasure he is not entitled to the frequent and long-continued exercise of this fraternal courtesy without conceding to the physician who acts for him the fees accruing from the duties discharged by the latter.

SECTION 2. Obstetrical and surgical cases involve unusual fatigue and responsibility, and it is just that the fees accruing therefrom should belong to the physician who attends them.

Article IV.—Duties of Physicians in Regard to Consultations.

SECTION 1. A complete medical education, of which the diploma of a medical college is the formal voucher, furnishes the only presumptive evidence of professional acquirements and abilities. But the annals of the profession contain the names of some who, not having the advantage of a complete medical education, became, nevertheless, through their own exertions and abilities, brilliant scholars and successful practitioners. A practitioner, therefore, whatever his credentials may be, who enjoys a good moral and professional standing in the community, should not be excluded from fellowship, nor his aid rejected, when it is desired by the patient in consultation. No difference in views on subjects of medical principles or practice should be allowed to influence a physician against consenting to a consultation with a fellow-practitioner. The very object of a consultation is to bring together those who may, perhaps, differ in their views of the disease and its appropriate treatment, in the hope that, from a comparison of different views, may be derived a just estimate of the disease and a successful course of treatment.

No tests of orthodoxy in medical practice should be applied to limit the freedom of consultations. Medicine is a progressive science. Its history shows that what is heresy in one century may and probably will be orthodoxy in the next. No greater misfortune can befall the medical profession than the action of an influential association or academy establishing a creed or standard of orthodoxy or "regularity." It will be fatal to freedom and progress in opinion and practice. On the other hand, nothing will so stimulate the healthy growth of the profession, both in scientific strength and in the honorable estimation of the public,

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as the universal and sincere adoption of a platform which shall recognize and guarantee:

1. A truly fraternal good will and fellowship among all who devote themselves to the care of the sick.

2. A thorough and complete knowledge, however obtained, of all the direct and collateral branches of medical science—as it exists in all sects and schools of medicine—as the essential qualification of a physician.

3. Perfect freedom of opinion and practice, as the unquestionable prerogative of the practitioner, who is the sole judge of what is the best mode of treatment in each case of sickness intrusted to his care.

The physician may, with propriety, decline to meet a practitioner of whose inimical feelings towards himself or of whose general unfairness in consultations he is satisfied. But in such a case he should explain to the patient his reasons; and if the patient desire the opinion of the practitioner objected to the family physician may withdraw from the case and allow the other to be sent for. But in justice to the latter the state of affairs should be explained to him at the time he is requested to visit the patient.

SECTION 2. The utmost punctuality should be observed in the visits of physicians when they are to hold consultations together; and this is generally practicable, for society allows the plea of professional engagements to excuse the neglect of all others, and to be a valid reason for the relinquishment of any present occupation. But as professional engagements may sometimes interfere and delay one of the parties, the physician who first arrives should wait for his associate a reasonable period of time, after which the consultation should be considered postponed to a new appointment. If it be the attending physician who is present he will, of course, see the patient and prescribe; but if it be the consulting physician he should retire without seeing the patient, except in case of emergency, or when he has been called from a considerable distance, in which case he may examine the patient and give his opinion in writing and under seal, to be delivered to the attending physician.

SECTION 3. In consultations no rivalry or jealousy should be indulged in. Candor, probity and all due respect should be exercised toward the physician in charge of the case. If the consulting physician cannot agree with him respecting the nature and proper

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treatment of the case the physician should state this fact to the patient or his nearest friend, both physicians being present at the time, and should request him to select the one in whom he has most confidence. But if they agree sufficiently to take joint charge of the case, then the consulting physician must justify and uphold, so far as he can conscientiously do so, the practice of his associate, and must abstain from any hints, insinuations or actions which might in any way impair the confidence which the patient reposes in him, or affect his reputation. He must refrain from any extraordinary attentions or assiduities calculated to ingratiate himself in the patient's favor and to supplant his associate.

SECTION 4. In consultations the attending physician should first put the necessary questions to the patient. After this the consulting physician should make such additional inquiries and examinations as may be needed to satisfy him of the true nature of the case. But he should avoid making a parade of examining the patient more thoroughly than had been done before, rather suggesting to the attending physician, where this is possible, to make whatever examinations he desires, than making them himself. Both physicians should then retire to a private room for deliberation.

SECTION 5. In consultations the attending physician should deliver his opinion first; and, when there are several consulting physicians, they should express their opinions in the order in which they have been called in. Should an irreconcilable diversity of opinion occur, when more than two physicians meet in consultation, the opinion of the majority should be regarded as decisive; but, if the number be equal on each side, the decision should rest with the attending physician. If two physicians, in consultation, cannot agree they should call in a third to act as umpire. If this be not practicable the patient must be requested to select the physician in whom he is most willing to confide. The physician who is left in the minority should, without any ill-feeling, retire from the consultation and from any farther participation in the management of the case; and, in justice to the physician thus retiring, the fact of his difference from his associates should, in the presence of all the physicians attending, be explained to the patient as his reason for withdrawing from the case.

SECTION 6. The attending physician should communicate to the patient or his friends the directions agreed upon in the consultation, as well as any opinion which it may be thought proper

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to express. But no statement or discussion should take place before the patient or his friends, except in the presence of all the physicians attending, and by their common consent. And no opinions or prognostications should be delivered which are not the result of previous deliberation and concurrence. No decision arrived at in a consultation is to be regarded as restraining the attending physician from making such variations in the treatment as any subsequent change in the case may demand. But such variation, and the reason for it, ought to be carefully noted at the time, and detailed at the next meeting in consultation. The same privilege belongs also to the consulting physician, if he is sent for in an emergency when the attending physician is out of the way; and similar explanations must be made by him at the next meeting.

SECTION 7. Sometimes a special consultation is desirable in cases in which the continued attendance of two physicians might be objectionable to the patient. The consulting physician, in such a case, should sedulously avoid all further unsolicited attendance. Such consultations require an extraordinary outlay of time and attention, and at least a *double honorarium* may be reasonably expected.

SECTION 8. The consulting physician cannot, with propriety, take exclusive charge at any time of the patient in whose case he has been called in consultation without the consent of the attending physician, except in cases provided for by the third sentence of section 3, and by the fourth sentence of section 5, of this article.

Article V.—Duties of Physicians in Cases of Interference.

SECTION 1. Medicine is a liberal profession, and those admitted into its ranks should base their expectations of success upon the extent of their qualifications, not upon intrigue or artifice. A physician should not allow himself to feel envious or jealous of a brother-practitioner. The distinction which one successful physician wins is shared by the whole profession. Nor should a physician suffer himself to feel ill-will towards another who may come into his neighborhood and appears likely to take a share of the business which he has hitherto enjoyed. Such feelings are inconsistent with the beneficent and liberal nature of the profession. Liberality and true generous fraternity in thought, word and deed will unite the interests of all the members of the profes-

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sion, and will so exalt the estimation in which it is held in the community that, confidence being increased, business will likewise increase; and to physicians will be accorded the position which, of right, should be theirs, that of confidential family advisers in all matters pertaining to the care of the body in health no less than in sickness.

SECTION 2. The physician, in his intercourse with a patient who is under the care of another practitioner, should observe the strictest caution and reserve. No meddling questions should be asked in any interview for business or friendship, no disingenuous hints thrown out relating to the nature and treatment of his disorder; nor should the patient be allowed to converse upon these topics. No course of conduct should be pursued which might, directly or indirectly, tend to diminish the trust reposed in the physician employed.

SECTION 3. A physician should not take charge of a patient who is, or has recently been, under the charge of another practitioner in the same illness, except in cases of sudden emergency, or in consultation with the physician previously in attendance, or when the latter has relinquished the case, or has been regularly notified that his services are no longer required. Under such circumstances no unjust or illiberal remarks should be made or insinuations thrown out in relation to the treatment pursued by the previous physician. Nor should the physician permit the patient unreasonably to find fault with his predecessor, for patients often become dissatisfied with their attendant on account of the mere duration of a case which no degree of professional knowledge or skill could have shortened.

SECTION 4. In cases of accident or sudden emergency one or more physicians are often sent for by alarmed friends. Courtesy should assign the patient to the first of these that arrives; and he should select from those present such additional assistance as he may deem necessary. But he should also request the family physician (if there be one) to be sent for, and on his arrival, resign the case into his hands. The practitioner of the patient, when he arrives, should take the place of any one called in his absence. "The practitioner of any patient" is the man whom he has in any way given to understand that he regards him as his medical adviser, or who would now be in charge of the case were it not for his absence, sickness or other disability.

SECTION 5. In a sparse population, a physician, when visiting

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a sick person, may be desired to see, in an emergency, a neighboring patient, who is under the regular charge of another physician. The conduct to be pursued on such an occasion is to give advice adapted to present circumstances; to interfere as little as possible with the general plan of treatment; to assume no farther direction of the case unless it be expressly desired; and, in the latter case, to request an immediate consultation with the practitioner previously employed.

SECTION 6. A wealthy physician should not give advice *gratis* to the affluent, because his so doing is an injury to his professional brethren. The office of the physician can never be supported as an exclusively beneficent one; and it is defrauding, in some degree, the common fund when fees are dispensed with which might justly be claimed.

SECTION 7. When a physician who has been engaged to attend a case of midwifery is absent, and another is sent for, if delivery is accomplished in the absence of the former, the latter is entitled to the fee, but he should resign the patient to the practitioner first engaged.

Article VI.—Of Differences between Physicians.

SECTION 1. Diversity of opinion and opposition of interests may, in the medical, as in other professions, sometimes occasion controversy and even contention. When such cases occur and cannot be immediately terminated, they should be referred to the arbitration of a sufficient number of physicians or a *court-medical.*

Article VII.—Of Pecuniary Acknowledgments.

SECTION 1. Some general rules should be adopted by the physicians in every town or district relative to pecuniary acknowledgments from patients. These should be adhered to by physicians as uniformly as circumstances will permit. They serve, likewise, as a standard to which appeal may be taken in cases of doubt or dispute.

SECTION 2. Members of the medical profession have been so uniformly in the habit of attending, gratuitously, the indigent sick, and, in general, of answering every call promptly and without a question as to whether they are to receive remuneration therefor, that many persons seem to think they have a right to demand the services of physicians, and do, in fact, call upon them freely, and neglect or refuse to render any pecuniary equivalent,

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although abundantly able to do so. They impose upon one physician in this way until they have exhausted his patience, and then call upon another; and thus, in the course of a few years, make the circuit of the profession in their neighborhood. It is proper for the physicians of a community to make a list of the names of such individuals, and to demand, before visiting those whose named are on it, adequate security that their *honorarium* will be paid.

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PART III.

THE RECIPROCAL DUTIES AND OBLIGATIONS OF PHYSICIANS AND THE PUBLIC.

Article I.—Duties of Physicians to the Public.

SECTION 1. As good citizens, it is the duty of physicians to be vigilant for the welfare of the community and to bear their part in sustaining its institutions and burdens. They should be always ready to give counsel to the public in relation to matters appertaining to their profession, as, for example, on subjects of medical police, public hygiene and legal medicine. It is their province to enlighten the public in regard to quarantine regulations, the location, arrangements and dietaries of hospitals, asylums, schools, prisons and similar institutions; in relation to the medical police of towns, drainage, ventilation, etc., and in regard to measures for the prevention of epidemic and contagious diseases. And, when pestilence prevails, it is their duty to face the danger and to continue their labors for the alleviation of suffering and the saving of life, even at the risk of their own lives.

SECTION 2. Physicians should always be ready, when called on by the proper authorities, to enlighten coroners' inquests and courts of justice on matters strictly medical, such as involve questions relating to insanity, legitimacy, or sudden and violent deaths, and in regard to the various other subjects embraced in the science of medical jurisprudence. But, in these cases, and especially where they are required to make post-mortem examinations, it is just and right, in consequence of the time, labor and skill required and the responsibility and risk they incur, that the public should award them more than a mere consulting fee.

SECTION 3. There is no profession, by the members of which eleemosynary services are more freely dispensed than they are by physicians; but justice demands that some limits should be placed to the claims upon such offices at their hands. Poverty, professional brotherhood, the benevolent and scantily remunerated occu-

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pation of the individual patient, and certain of the public duties referred to in Section 1 of this Article, should always be recognized as presenting valid claims for gratuitous services. But neither institutions endowed by the public or by rich individuals, societies for mutual benefit, for the insurance of lives or for analogous purposes, nor any profession or occupation can be admitted to possess such privilege. Nor can it be justly expected of physicians to furnish certificates of inability to serve on juries, or perform military duty, or to certify to the state of health of parties wishing to insure their lives, obtain pensions or the like, without a pecuniary acknowledgment. But to indigent persons such professional services should always be cheerfully and freely accorded.

Article II.—Obligations of the Public to Physicians.

SECTION 1. The benefit accruing to the public, directly and indirectly, from the active and constant labors and beneficence of the medical profession are so numerous and important that physicians are justly entitled to the utmost consideration from the community. The public ought, likewise, to entertain a just appreciation of the proper qualifications of a practitioner of medicine; to make a due discrimination between true science and the assumptions of ignorance and empiricism; to afford every encouragement and facility for the acquisition of medical education, and not to allow the provisions of their statute-books or of the prospectus of their chartered institutions to interpose any obstacles to the attainment of the fullest knowledge of every branch of medical science, or, in any way, to restrain the most entire freedom of thought, investigation and action in matters appertaining to the practice of medicine.

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COMPLETE REPORT OF THE BOARD OF CENSORS

PHYSICIANS ELECTED TO MEMBERSHIP

ADAMS, ERNEST O.....1617 Wilson Ave., Cleveland, O.
Cleveland Homœopathic Hospital College, 1893.

ALDRICH, STEWART W.....Grand Ave., Des Moines, Ia.
Cleveland Homœopathic Hospital College, 1875.

ARMSBURY, AARON B.....Marine City, Mich.
Cleveland Homœopathic Medical College, 1897.

ARNOLD, OLIVER HENRY.....275 Washington St., Providence, R. I.
Harvard Medical School, 1867.

AUGUSTIN, GEORGE WILLIAM.....469 Third Ave., Detroit, Mich.
New York Homœopathic Medical College and Hospital, 1899.

BAKER, ALBERT L.....1400 12th Ave., Altoona, Penn.
Hahnemann Medical College, Philadelphia, 1893.

BAKER, HARRY H.....710 E. Main St., Muncie, Ind.
Chicago Homœopathic Medical College, 1897.

BEACH, ELIZA J ..... 50 Worcester Ave., Pasadena, Cal.
Homœopathic Hospital College, Cleveland, 1876.

BEATTIE, JOSEPH HOYT.....Warwick, N. Y.
New York Homœopathic Medical College and Hospital, 1902.

BIBIGHOUSE, JAMES RUSSELL...2156 Natrona St., Philadelphia, Pa.
Hahnemann Medical College, Philadelphia, 1902.

BISSELL, FRED. C.....13 North Main St., Oberlin, Ohio.
Cleveland Homœopathic Medical College, 1899.

BLACKBURN, EDWIN C.....1421 11th Ave., Altoona, Pa.
Hahnemann Medical College, Philadelphia, 1896.

BLAIR, THOS. L.....Waynesburg, Pa.
Pueblo Medical College, 1891.

BURCHFIELD, SAMUEL NEWTON.....39 E. Main St., Titusville, Pa.
Chicago Homœopathic Medical College, 1887.

CASH, NATHAN.....69 Third St., Uhrichsville, O.
College Physicians and Surgeons, Keokuk, Ia., 1865.

CHAMBLIN, BAYLES.....2427 N. Grand Ave., St. Louis, Mo.
Homœopathic Medical College of Missouri, 1886.

CHASE, SHERMAN F.....Caro, Mich.
Detroit Homoœopathic Medical College, 1872.

CLAYPOOL, JOHN B.....156 Furnace St., Niles, O.
Hahnemann Medical College and Hospital, Philadelphia, 1893.

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COGSWELL, CHARLES H.....1011 2d Ave., Cedar Rapids, Ia.
College of Homœopathic Medicine, State University, 1902.

COLE, GEORGE HARVEY.....311 Main St., Conneaut, O.
Cleveland Homœopathic Medical College, 1892.

COLLINS, ALLEN BENNETT.....Linesville, Pa.
Cleveland Homœopathic Medical College, 1895.

CONRAD, CHAS. K.....18 E. Vine St., Mt. Vernon, O.
Homœopathic Hospital College of Cleveland, 1890.

CONKLIN, WINFIELD EDWIN....2814 Groveland Ave., Chicago, Ill.
Hahnemann Medical College, 1902.

COOK, W. CASPER.....501 Bijou Bldg., Pittsburg, Pa.
Chicago Homœopathic Medical College, 1890.

COOPER, ROY CUMMINGS.....Bank Bldg., Bellevue, Pa.
Boston University School of Medicine, 1901.

CORNUE, P. W.....49 Washington St., Ypsilanti, Mich.
Chicago Homœopathic Medical College, 1894.

CRAMER, NORMAN A.....Denver, Colo.
Denver Homœopathic Hospital, 1902.

CUMMER, ROBT. J.....396 Bolton Ave., Cleveland, O.
Cleveland Homœopathic Medical College, 1895.

CURTIS, HELEN ENDORA.....314 Second St., Marietta, O.
New York College and Hospital for Women, 1881.

DAMON, G. J.....Medina, O.
Cleveland Homœopathic Hospital College, 1886.

DAVIES, J. NORMAN.....209 Third St., Warren, Pa.
Hahnemann Medical College, 1891.

DE CAMP, FRANK HURD.....410 William St., Elmira, N. Y.
New York Homœopathic Medical College and Hospital, 1892.

DEVITT, FREDERICK WM.....Deep River, Conn.
Cleveland Medical College, 1897.

DIEHEL, WM. H.....505 Mack St., Detroit, Mich.
Cleveland Homœopathic Medical College, 1901.

DILLMAN, DANIEL.....Chippewa Lake, Ohio.
Cleveland Homœopathic Hospital College, 1890.

DIMON, ROBERT B.....70 E. Main, Massillon, Ohio.
Hahnemann Medical College, Chicago, 1896.

DODGE, JOHN B.....St. Johns, Mich.
Homœopathic Medical College, University of Michigan, 1880.

ECKI, SIMON P.....365 Park Ave. W., Mansfield, Ohio.
New York Homœopathic Medical College, 1881.

EDMUNDS, CHARLES W.....Sixth and Adams Sts., Bay City, Mich.
University of Michigan Homœopathic Medical College, 1900.

EVERETT, EDW.....5 E. Main, Madison, Wis.
Hahnemann Medical College, Chicago, 1882.

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FAUST, FREDERICK A...21 E. Platte Ave., Colorado Springs, Colo.
New York Homœopathic Medical College, 1886.

FRANZ, ERNEST.....Boone, Ind.
Hahnemann Medical College and Hospital, Chicago, 1893.

FRIZZELL, JOHN W.....61 Central Ave., Great Falls, Mont.
Cleveland Homœopathic Medical College, 1884.

GASTON, SARAH P.....Main St., Niles, Ohio.
Cleveland University of Medicine and Surgery, 1895.

GAULT, WM. EDWARD.....96 E. Second St., Portsmouth, Ohio.
Pulte Medical College, 1897.

GINN, ARBA S.....307-8 Federal Bldg., Youngstown, Ohio.
Chicago Homœopathic Medical College, 1898.

GRAHAM, ALFRED.....270 Woodward Ave., Detroit, Mich.
Hahnemann Medical College, Philadelphia, 1885.

GRIGGS, O. P.....42 Center, Ashtabula, Ohio.
Cleveland Homœopathic Hospital College, 1881.

HARRELL, M. H.....96 N. Tenth St., Nashville, Ind.
Homœopathic Medical College of Missouri, 1881.

HANDMACHER, DAVID.....2260 Broadway, Cleveland, Ohio.
Cleveland Homœopathic Medical College, 1896.

HENDRIX, JOHN OLIVER.....Castle Bldg., Frederick, Md.
Southern Homœopathic Medical College, 1894.

HEWELL, W. S.....O. S. and S. O. Home, Xenia, Ohio.
Homœpathic Hospital College, Cleveland, 1888.

HIND, WM. HENRY WEED.....52 Nashua, Milford, N. H.
Boston University School of Medicine, 1895.

HODSON, GEO. STANTON.....Washington Courthouse, Ohio.
Pulte Medical College, 1894.

HOFF, EDWIN C.....Grace Hospital, Detroit, Mich.
Cleveland Homœopathic Medical College, 1901.

HOLLY, EUGENE DEALTON.....Owego and Main, Candor, N. Y.
Cleveland Homœopathic Medical College, 1897.

HOOVER, JULIA E.....145 Taylor St., Cleveland, Ohio.
Cleveland Homœopathic Medical College, 1900.

HORTON, DANIEL J.....Evans, Colo.
Denver Homœopathic Medical College, 1900.

HOYT, HERBERT W.....75 South Fitzhugh St., Rochester, N. Y.
Boston University School of Medicine, 1891.

JACOBSON, FRANK AIKENS.....269 Grand St., Newburg, N. Y.
New York Homœopathic Medical College and Hospital, 1898.

JAMES, KATHARINE E.....123 N. Main St., Rockford, Ill.
Hahnemann Medical College, Chicago, 1895.

JEND, GUSTAV ADOLPH.....1194 Sayne Ave., Cleveland, Ohio.
Pulte Medical College, 1897.

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JEWETT, HOWARD CLIFTON.....75 Vine St., Haverhill, Mass.
New York Homœopathic Medical College and Hospital, 1888.

JOHNSON, CHARLES WARD.....35 E. Monroe, Jacksonville, Fla.
Cleveland Homœopathic Hospital College, 1881.

JOHNSON, ANNA.....5115 Liberty Ave., Pittsburg, Pa.
Cleveland Homœopathic Medical College, 1898.

JONES, GEO. W.....310 Caxton Bldg., Cleveland, Ohio.
Cleveland Homœopathic Medical College, 1902.

JONES, W. E.....3859 Page Ave., St. Louis, Mo.
Homœopathic Medical College of Missouri, 1897.

JUNKERMANN, CHARLES F.....405 N. Broad, Lancaster, Ohio.
Hahnemann Medical College and Hospital, Chicago, 1887.

KAPP, MICHAEL WM.....32 Central Office Bldg., Akron, Ohio.
Cleveland Homœopathic Medical College, 1895.

KINYON, HENRY E.....9 Fuller St., Fullerton, Neb.
Hahnemann Medical College, Chicago, 1890.

KETCHUM, FREDERICK GRANT....Postoffice Bldg., Valparaiso, Ind.
Hahnemann Medical College, Chicago, 1893.

KLEIN, A. KATHARINE.....172 Bowers St., Jersey City, N. J.
New York Medical College for Women, 1899.

LEWIS, FRED LYMAN.....1854 Pearl St., Cleveland, Ohio.
Cleveland University of Medicine and Surgery, 1897.

LESLIE, SAMUEL BREWSTER.....Okmulgee, I. T.
Denver Homœopathic Medical College, 1902.

LYTLE, JOSEPH ALLGYER.....718 Rose Bldg., Cleveland, Ohio.
Cleveland Homœopathic Medical College, 1898.

MARTIN, CHAS. VELAS.....2814 Groveland Ave., Chicago, Ill.
Hahnemann Medical College, Chicago, 1901.

MATCHETT, JOHN.....Summerfield, Kas.
Kansas City Homœopathic Medical College, 1894.

MCBRIDE, LEWIS E.....78 Thirteenth St., Franklin, Pa.
Chicago Homœopathic Medical College, 1895.

MCBURNEY, BENJ. A...200 South Park Ave., Austin Sta., Chicago.
Chicago Homœopathic Medical College, 1896.

MCCAULEY, E. S. H.....Beaver, Pa.
Cleveland Homœopathic Medical College, 1897.

MCCONKEY, THOMAS GRAHAM...406 Sutter St., San Francisco, Cal.
University of Pennsylvania Medical Department, 1890.

METCALF, HIRAM HULBERT.....Chicago, Ohio.
Cleveland Homœopathic Medical College, 1897.

MILLER, HARRY T.....113 E. High St., Springfield, Ohio.
New York Homœopathic Medical College and Hospital, 1888.

MINAKER, ANDREW J.....291 Valencia St., San Francisco, Cal.
Hahnemann Hospital College of San Francisco, 1899.

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MORRIS, WM. TURNER.....1407 Chapline St., Wheeling, W. Va.
Pulte Medical College, 1902.

MUHLEMAN, CHAS.....611 Market St., Parkersburg, W. Va.
Cleveland Homœopathic Hospital College, 1882.

MUKURJEE, A. N..Children's Homœopathic Hospital, Philadelphia.
Hahnemann Medical College, Philadelphia, 1902.

NASH, EUGENE B.....28 Clinton Ave., Courtland, N. Y.
Cleveland Homœopathic Hospital College, 1874.

NICHOLSON, HARRY SCHUYLER.....621 Arch St., Allegheny, Pa.
Hahnemann Medical College, Philadelphia, 1902.

NOBLES, NEWMAN T. B.....3176 Euclid Ave., Cleveland, Ohio.
Cleveland University of Medicine and Surgery, 1896.

NOBLES, WM. C. E.....Main St., Littleton, N. H.
Cleveland University of Medicine and Surgery, 1897.

PALMER, HARRY E.....226 North Main St., Dayton, O.
New York Homœopathic Medical College, 1885.

PECK, HARRY G.....Columbus, Wis.
Chicago Homœopathic Medical College, 1894.

PERKINS, CHAS. WINFIELD.....Metropolitan Hospital, N. Y.
Hahnemann Medical College, Philadelphia, 1901.

PERRY, W. H.....Unionville, Mo.
Homœopathic Medical College of Missouri, 1898.

PHILLIPS, JOSEPH R.....15 East Eighth St., Erie, Pa.
Cleveland Homœopathic Medical College, 1883.

PLINCHER, WM. ALLEN.....5915 Walker St., Philadelphia, Pa.
Hahnemann Medical College, Philadelphia, 1896.

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New York Homœopathic Medical College and Hospital, 1899.

PUTNEY, WILLIS S.....Broad St., Milford, Conn.
New York Homœopathic Medical College, 1882.

RANKIN, JOHN E.....1185 Dean St., Brooklyn, N. Y.
New York Homœopathic Medical College, 1901.

RANSOM, ELIZA TAYLOR....373 Commonwealth Ave., Boston, Mass.
Boston University School of Medicine, 1900.

RILEY, C. T.....New Matamoras, O.
Pulte Medical College.

RIZER, ALFRED L.....318 No. Cleve Ave., Canton, O.
Detroit Homœopathic Medical College, 1872.

ROBBINS, A. JEROME.....Mayville and Chautauqua, N. Y.
Southern Homœopathic Medical College, 1896.

ROGERS, JESSE BELMONT.....118 E. Sixth St., Michigan City, Ind.
Hahnemann Medical College, Chicago, 1895.

ROWLAND, JUSTIN E.....South Euclid, O.
Cleveland Homœopathic Medical College, 1891.

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Cleveland Homœopathic Medical College, 1895.

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Pulte Medical College, 1900.

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Western Homœopathic College, 1865.

SCHLESSELMAN, JNO. THEODORE.....Good Thunder, Minn.
Cleveland University of Medicine and Surgery, 1897.

SEARS, ALBERT H.....139 W. Ninth St., Anderson, Ind.
Hahnemann Medical College, Chicago, 1890.

SELLEW, SYLVESTER WOLCOTT.....17 Center St., Oil City, Pa.
Homœopathic Hospital College, Cleveland, 1882.

SHANNON, ELMER ELLSWORTH.....Ivoryton, Conn.
Cleveland Homœopathic Medical College, 1898.

SHARP, JOHN R.....Homœopathic Hospital, Washington, D. C.
Hahnemann Medical College, Philadelphia, 1901.

SHUFFLETON, FRANK A.....209 W. High St., St. Marys, O.
Hahnemann Medical College, Philadelphia, 1900.

SIMMONS, S. E.....82 W. Main St., Norwalk, O.
Pulte Medical College, 1881.

SOUTHER, ROBERT F.....1122 Commonwealth Ave., Boston, Mass.
Boston University School of Medicine, 1899.

STEPFIELD, ALEXANDER E.....Doylestown, O.
Cleveland Homœopathic Hospital College, 1883.

STEPHENS, CHAS. N.....1899 Milwaukee Ave., Chicago, Ill.
Chicago Homœopathic Medical College, 1896.

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Hahnemann Medical College, Chicago, 1886.

STEWART, WM. R.....129 E. Ohio St., Indianapolis, Ind.
Hahnemann Medical College, Chicago, 1890.

STORER, JOHN.....1106-92 State St., Chicago, Ill.
Hahnemann Medical College, Chicago, 1889.

STOUGH, CHARLES FRANCIS...122 E. Kiowa, Colorado Springs, Col.
Chicago Homœopathic Medical College, 1895.

STREETER, GEORGE DALLAS.....216 N. Fifth St., Waco, Tex.
Hahnemann Medical College, Philadelphia, 1872.

SUGANUMA, MARY A.....Nagaski, Japan.
Cleveland Homœopathic Hospital College, 1883.

TAYLOR, WM. GARDINER.....216 Locust St., Columbia, Pa.
Hahnemann Medical College, Philadelphia, 1870.

TILTON, NELLIE MORRIS.....15 Bartlett St., Brockton, Mass.
Boston University School of Medicine, 1902.

TREGO, WM. EDGAR.....1463 Cedar Ave., Cleveland, Ohio.
Chicago Homœopathic Medical College, 1894.

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Boston University School of Medicine, 1894.

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Homœopathic Hospital College, Cleveland, 1897.

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Cleveland Homœopathic Medical College, 1896.

VINYARD, GUY STEWART.....1517 Welton St., Denver, Colo.
Denver Homœopathic Medical College, 1901.

WALDO, ELMER E.....1052 Broadway, Hannibal, Mo.
Chicago Homœopathic Medical College, 1894.

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Cleveland Homœopathic Medical College, 1874.

WALLACE, C. R.....Struthers, Ohio.
Cleveland Homœopathic Medical College, 1897.

WALLACE, HOMER DAWSON.....214 Laycock St., Allegheny, Pa.
Cleveland Homœopathic Medical College, 1901.

WALTZ, ALVAN L.....526 Prospect St., Cleveland, Ohio.
Cleveland Homœopathic Hospital College, 1883.

WELCH, CHARLES EDGAR.....12 West Columbus, Nelsonville, Ohio.
Hahnemann Medical College and Hospital, Chicago, 1896.

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Pulte Medical College, 1877.

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Hahnemann Medical College, Chicago, 1878.

WHITE, FLORENCE R. SMITH.....Cardington, O.
Cleveland Homœopathic Hospital College, 1884.

WHITAKER, HARRY O.....South Charleston, O.
Cleveland Homœopathic Medical College, 1901.

WHITEHEAD, J. H.....43 Church St., Bowling Green, O.
Cleveland Homœopathic Hospital College, 1874.

WIGGINS, C. C.....Osage, Ia.
Chicago Homœopathic Medical College, 1889.

WILKINS, GEO. R.....658 W. Madison Ave., Cleveland, O.
Cleveland Homœopathic Medical College, 1899.

WILKINSON, CHAS. H.....423 Macon Ave., Canon City, Col.
Cleveland University of Medicine and Surgery, 1897.

WILSON, CHAS. A.....313 E. Houston St., San Antonio, Tex.
Cleveland Homœopathic Hospital College, 1883.

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New York Homœopathic Medical and Hospital, 1883.

WINNARD, WELLINGTON LEROY.....422 Main, Warsaw, Ill.
Chicago Homœopathic Medical College, 1890.

WOLLAM, J. FRANK.....Jerry, O.
Hahnemann Medical College, Chicago, 1893.

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New York Homœopathic Medical College, 1874.

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Hahnemann Medical College, Philadelphia, 1880.

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Cleveland Homœopathic Medical College, 1895.

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Chicago Homœopathic Medical College, 1900.

YOUNG, JAS. W.....Bellefontaine, O.
Cleveland University of Medicine and Surgery, 1896.

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Homœopathic Medical College of Missouri, 1891.

ZBINDEN, CHRISTIAN.....431 Nebraska Ave., Toledo, O.
Cleveland Homœopathic Hospital College, 1882.

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Brown, Lucy H. A., M. D.....Providence, R. I.
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COLE, HARLAN P., M. D.....Hartford, Conn.
COLLINS, ALLEN B., M. D.....Linesville, Pa.
COLLINS, D. D., M. D.....Chicago, Ill.
COLLINS, NEWTON M., M. D.....Rochester, N. Y.
CONNELL, RALPH W., M. D.....Omaha, Neb.
CONNELL, ROBERT D., M. D.....Columbus, Ohio.
CONRAD, CHARLES K., M. D.....Mt. Vernon, Ohio.
CONKLIN, WINFRED E., M. D.....Chicago, Ill.
COOK, JOSEPH T., M. D.....Buffalo, N. Y.
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COOLIDGE, JOHN W., M. D.....Scranton, Pa.
COON, GEORGE S., M. D.....Louisville, Ky.
COONS, HENRY N., M. D.....Lebanon, Ind.
COPELAND, ROYAL S., M. D.....Ann Arbor, Mich.
CORNELL, P. W., M. D.....Ypsilanti, Mich.
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Mann, Eugene L., M. D.....St. Paul, Minn.
Marshall, Robert S., M. D.....Pittsburg, Pa.
Martin, Charles V., M. D.....Chicago, Ill.
Martin, G. Forrest, M. D.....Lyon, Mass.
Martin, Lynn A., M. D.....Binghamton, N. Y.
Maxwell, Lewis K., M. D.....Toledo, Ohio.
McBean, George M., M. D.....Chicago, Ill.
McBirney, B. A., M. D.....Chicago, Ill.
McBride, L. E., M. D.....Franklin, Pa.
McCann, T. A., M. D.....Dayton, Ohio.
McCauley, E. S. H., M. D.....Beaver, Pa.
McCauley, J. C., M. D.....Rochester, Pa.
McCleary, J. R., M. D.....Marietta, Ohio.
McConkey, Thomas G., M. D.....San Francisco, Cal.
McDowell, George W., M. D.....New York, N. Y.
Menninger, Charles F., M. D.....Topeka, Kan.
Metcalfe, H. H., M. D.....Chicago Junction, Ohio.
Miller, John, M. D.....Buffalo, N. Y.
Millsop, Sarah J., M. D.....Bowling Green, Ky.
Minor, Mary E., M. D.....Cincinnati, Ohio.
Mitchell, Clifford, M. D.....Chicago, Ill.
Montgomery, Phinneas J., M. D.....Council Bluffs, Iowa.
Moon, Seymour B., M. D.....Beaver Falls, Pa.
Moore, J. Herbert, M. D.....Brookline, Mass.
Morgan, Willis B., M. D.....St. Louis, Mo.
Morley, Frank W., M. D.....Sandusky, Ohio.
Morris, John W., M. D.....Wheeling, W. Va.
Morrison, Frank A., M. D.....Uhrichsville, Ohio.
Morrow, Emory H., M. D.....Altoona, Pa.
Moseley, George T., M. D.....Buffalo, N. Y.
Mueller, Gustave A., M. D.....Pittsburg, Pa.
Nash, E. V., M. D.....Cortland, N. Y.
Newton, Frank L., M. D.....Somerville, Mass.
Nicholas, George D., M. D.....Cleveland, Ohio.
Nickelson, W. H., M. D.....Adams, N. Y.
Nobles, N. T. B., M. D.....Cleveland, Ohio.
Nobles, W. C. E., M. D.....Lyttleton, N. H.
Norton, Arthur B., M. D.....New York, N. Y.
Norton, Claude R., M. D.....Philadelphia, Pa.

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OGDEN, BENJAMIN H., M. D.....St. Paul, Minn.
ORLEMAN, E. LOUISE, M. D.....Detroit, Mich.
OSTRANDER, P. M., M. D.....Nunda, N. Y.
OVERPECK, JAMES W., M. D.....Hamilton, Ohio.
PAINE, RICHARD K., M. D.....Manitowoc, Wis.
PALMER, A. WORRALL, M. D.....New York, N. Y.
PALMER, H. E., M. D.....Dayton, Ohio.
PALMER, OWEN A., M. D.....Cleveland, Ohio.
PARR, J. D., M. D.....Marietta, Ohio.
PARSONS, EDGAR C., M. D.....Meadville, Pa.
PARSONS, KATE, M. D.....Cleveland, Ohio.
PARTRIDGE, BARTON S., M. D.....East Bloomfield, N. Y.
PATERSON, WILLIAM, M. D.....Cleveland, Ohio.
PATTERSON, JOSEPH M., M. D.....Kansas City, Mo.
PAULEY, CHARLES A., M. D.....Cincinnati, Ohio.
PAYNE, CLARENCE N., M. D.....Bridgeport, Conn.
PECK, GEORGE B., M. D.....Providence, R. I.
PECK, HARRY G., M. D. .....Columbus, Wis.
PERKINS, CHARLES W., M. D.....Chester, Pa.
PERRY, W. H., M. D.....Unionville, Mo.
PETTIT, EVELYN S., M. D.....New Brighton, Pa.
PHILLIPS, J. R., M. D.....Erie, Pa.
PHILLIPS, WILLIAM A., M. D.....Cleveland, Ohio.
PIERSON, HERMAN W., M. D.....Chicago, Ill.
PLUMB, AMY E., M. D.....Baltimore, Md.
POMEROY, HARLAN, M. D.....Cleveland, Ohio.
PORTER, EUGENE H., M. D.....New York, N. Y.
POWELSON, ARTHUR S., M. D.....Rochester, N. Y.
PULFORD, WILLIAM H., M. D.....Delaware, Ohio.
QUAY, GEORGE H., M. D.....Cleveland, Ohio.
QUILLIAM, FREDERICK F., M. D.....Cleveland, Ohio.
RALSTON, ROSE A., M. D.....Warren, Ohio.
RAND, JOHN P., M. D.....Munson, Mass.
REDDISH, ALBERT W., M. D.....Sidney, Ohio.
REED, R. G., M. D.....Cincinnati, Ohio.
RENWICK, WILLIAM J., M. D.....Auburn, Me.
REYNOLDS, JOHN N., M. D.....Grand Haven, Mich.
RICE, GEORGE B., M. D.....Boston, Mass.
RICHARDS, R. MILTON, M. D.....Detroit, Mich.
RICHARDSON, FRANCIS N., M. D.....Cleveland, Ohio.
RICKER, MARCENA S., M. D.....Rochester, N. Y.

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RILEY, C. F., M. D.....New Matamoras, Ohio.
RIZER, A. L., M. D.....Canton, Ohio.
ROMBINS, A. JEROME, M. D.....Mayville, N. Y.
ROBERTS, ARTHUR A., M. D.....Wellsburg, W. Va.
ROBERTS, DAVID J., M. D.....New Rochelle, N. Y.
ROBERTS, GEORGE W., M. D.....New York, N. Y.
ROBERTSON, HERBERT M., M. D.....Riverside, Cal.
ROCKWELL, JOHN A., M. D.....Harriman, Tenn.
ROPER, FREDERICK E., M. D.....Norwich, N. Y.
ROPER, PULASKI B., M. D.....Cleveland, Ohio.
ROSENBERGER, ABRAHAM S., M. D.....Covington, Ohio.
ROSSITER, EDWIN B., M. D.....Pottstown, Pa.
ROWLAND, J. E., M. D.....South Euclid, Ohio.
ROYAL, GEORGE, M. D.....Des Moines, Iowa.
RUMSEY, CHARLES L., M. D.....Baltimore, Md.
RUST, EDWIN G., M. D.....Cleveland, Ohio.
SANFORD, C. E., M. D.....Bridgeport, Conn.
SANDEL, JOHN H., M. D. .....Plymouth, Pa.
SANKETT, B. E., M. D.....New Castle, Pa.
SAWYER, CHARLES E., M. D.....Marion, Ohio.
SCHANTZ, M. MARGARET H., M. D.....Reading, Pa.
SCHLESSELMAN, J. T., M. D.....Good Thunder, Minn.
SCHNEIDER, ADOLPH B., M. D.....Cleveland, Ohio.
SCHREINER, EMMA T., M. D.....Philadelphia, Pa.
SCHULZE, CARL A., M. D.....Columbus, Ohio.
SCHELL, SAMUEL M., M. D.....Hamilton, Ohio.
SEARS, ALBERT H., M. D.....Anderson, Ind.
SELLEW, S. W., M. D.....Oil City, Pa.
SEYMOUR, GEORGE W., M. D.....Westfield, N. Y.
SHANNOCK, E. E., M. D.....Ivoryton, Conn.
SHEPARD, GEORGE A., M. D.....New York, N. Y.
SHERWOOD, HERBERT A., M. D.....Warren, Ohio.
SHUFFELTON, FRANK A., M. D.....St. Marys, Ohio.
SIGRIST, CHRISTOPHER W., M. D.....Columbus, Ohio.
SIGRIST, PHILIP H., M. D.....New Philadelphia, Ohio.
SIMMONS, N. R., M. D.....Toledo, Ohio.
SIMMONS, S. E., M. D.....Norwalk, Ohio.
SMITH, DEAN T., M. D.....Ann Arbor, Mich.
SMITH, JULIA HOLMES, M. D.....Chicago, Ill.

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Spranger, Michael J., M. D.....Detroit, Mich.
Spencer, Annie W., M. D.....Batavia, Ill.
Stauffer, Alvin P., M. D.....Hagerstown, Md.
Stearns, George R., M. D.....Buffalo, N. Y.
Stearns, William M., M. D.....Chicago, Ill.
Stepfield, A. E., M. D.....Doylestown, Ohio.
Stephens, Charles N., M. D.....Chicago, Ill.
Stephens, James A., M. D.....Cleveland, Ohio.
Stewart, Frank C., M. D.....Indianapolis, Ind.
Stewart, Thomas M., M. D.....Cincinnati, Ohio.
Stewart, W. R., M. D.....Indianapolis, Ind.
Stitzel, Jonas W., M. D.....Hollidaysburg, Pa.
Storer, John, M. D.....Chicago, Ill.
Stough, C. F., M. D.....Colorado Springs, Col.
Strickler, David A., M. D.....Denver, Col.
Stumpf, Daniel B., M. D.....Buffalo, N. Y.
Suffa, George A., M. D.....Boston, Mass.
Sutherland, John P., M. D.....Boston, Mass.
Swan, Charles J., M. D.....Chicago, Ill.
Swett, Emily F., M. D.....Medina, N. Y.
Symonds, E. A., M. D.....Carthage, N. Y.
Taylor, Elizabeth Y., M. D.....Grand Rapids, Mich.
Teets, Charles E., M. D.....New York, N. Y.
Thomas, Arthur E., M. D.....Chicago, Ill.
Thompson, Jay J., M. D.....Chicago, Ill.
Toles, Louise, M. D.....Cleveland, Ohio.
Tooker, Robert N., M. D. .....Chicago, Ill.
Townsend, Irving, M. D.....New York, N. Y.
Trego, W. E., M. D.....Cleveland, Ohio.
Truesdale, C. R., M. D.....Fremont, Ohio.
Tuttle, Edward G., M. D.....New York, N. Y.
Ullrey, Arthur O., M. D.....Niles, Mich.
Van Delinder, Effie M., M. D.....Beloit, Wis.
Van den Burg, William H., M. D.....New York, N. Y.
Van Lennep, William B., M. D.....Philadelphia, Pa.
Van Scoyoc, Lloyd G., M. D.....Kansas City, Mo.
Varney, Annie, M. D.....Wilkinsburg, Pa.
Varney, J. D., M. D.....Chesterville, Ohio
Waite, Kent B., M. D.....Cleveland, Ohio.
Walker, H. Ellen, M. D.....Sharon, Pa.

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WALLACE, C. R., M. D.....Struthers, Ohio.
WALLACE, H. D., M. D.....Allegheny City, Pa.
WALTZ, ALVAN L., M. D.....Cleveland, Ohio.
WARING, GUERNSEY P., M. D.....Chicago, Ill.
WARD, FLORENCE N., M. D.....San Francisco, Cal.
WARD, JAMES W., M. D.....San Francisco, Cal.
WARNER, ALTON G., M. D.....Brooklyn, N. Y.
WATSON, CARL, M. D.....Cleveland, Ohio.
WATTERS, WILLIAM H., M. D.....Boston, Mass.
WATTS, WILLIAM, M. D.....Toledo, Ohio.
WEBSTER, FRANK, M. D.....Dayton, Ohio.
WELCH, C. E., M. D.....Nelsonville, Ohio.
WELLIVER, J. E., M. D.....Dayton, Ohio.
WELLS, DAVID W., M. D.....Boston, Mass.
WELLS, LEVI C., M. D.....Cleveland, Ohio.
WHITAKER, H. O., M. D.....South Charlestown, Ohio.
WHITE, FLORENCE SMITH, M. D.....Cardington, Ohio.
WHITE, ROLAND T., M. D.....Allegheny City, Pa.
WHITEHEAD, J. H., M. D.....Bowling Green, Ohio.
WIGGINS, C. C., M. D.....Osage, Iowa.
WILCOX, DEWITT G., M. D.....Buffalo, N. Y.
WILCOX, SIDNEY F., M. D.....New York, N. Y.
WILKINS, GEORGE R., M. D.....Cleveland, Ohio.
WILKINSON, C. H., M. D.....Canon City, Col.
WILSON, CHARLES A., M. D.....San Antonio, Texas.
WILSON, JOHN E., M. D.....New York, N. Y.
WILSON, WILLIAM, M. D.....Akron, Ohio.
WILSON, W. HENRY, M. D.....Chicago, Ill.
WOLCOTT, EDWIN H., M. D.....Rochester, N. Y.
WOOD, FREDERICK W., M. D.....Chicago, Ill.
WOOD, JAMES C., M. D.....Cleveland, Ohio.
YOUNG, A. D., M. D.....Panama, N. Y.
YOUNG, G. A., M. D.....Asylum, Neb.
YOUNG, J. W., M. D.....Bellefontaine, Ohio.
YOUNG, WILLIS B., M. D.....St. Louis, Mo.
ZBINDER, C., M. D.....Toledo, Ohio.
ZIEGENFUS, A. FRANK, M. D.....Philadelphia, Pa.
ZWETSCH, J. D., M. D.....Gowanda, N. Y.

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RECAPITULATION

Number of Seniors	48
Number of Junior Members	425
Total number of members in attendance	473

ATTENDANCE BY STATES

From	Arkansas	1
"	California	7
"	Canada	4
"	Colorado	4
"	Connecticut	7
"	District of Columbia	4
"	Florida	1
"	Georgia	1
"	Illinois	47
"	Indiana	14
"	Iowa	7
"	Kansas	1
"	Kentucky	3
"	Maine	1
"	Maryland	4
"	Massachusetts	16
"	Michigan	32
"	Minnesota	5
"	Missouri	17
"	Nebraska	5
"	New Hampshire	2
"	New Jersey	8
"	New York	69
"	Ohio	136
"	Oregon	1
"	Pennsylvania	61
"	Rhode Island.	3
"	Tennessee	1
"	Texas	1
"	Virginia	1
"	West Virginia	3
"	Wisconsin	6
	Total	473

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REGISTER OF MEMBERSHIP

All members of the Institute who have maintained twenty-five consecutive years of membership shall be considered *Senior Members*, and be exempt from the payment of annual dues; and the names of such members shall be printed first in the list of members in capital letters.—*Article V., Section 6, of the By-Laws.*

There shall be published in each annual volume of the TRANSACTIONS: 1. A list of senior members arranged according to their years of membership. 2. An alphabetical list of members, including the names of senior members in CAPITALS. 3. A list of members classified by States. The list of deceased members shall be revised and republished annually. The complete list of members of the Institute from its organization and its Code of Ethics shall be published every five years.—*Article VIII., Section 4, of the By-Laws.*

SENIOR MEMBERS

1846.

BERENS, JOSEPH, 1500 Green Street, Philadelphia, Pa.
RHEES, MORGAN J., Wheeling, W. Va.

1847.

CHASE, HIRAM L., 924 Massachusetts Avenue, Cambridgeport, Mass.
SHACKFORD, RUFUS, Portland, Me.

1848.

GURNSEY, EGBERT, "The Madrid," 180 W. 59th Street, New York, N. Y.
PALMER, MILES W., 235 E. 18th Street, New York, N. Y.
RAYMOND, JONAS C., 626 Thirteenth Street, Oakland, Cal.

1850.

PAINE, HORACE M., West Newton, Mass.

1853.

ANGELL, HENRY C., 16 Beacon Street, Boston, Mass.
BISSELL, ARTHUR F., 133 Front Street, New York, N. Y.
SKILES, FRANCIS W., Suffolk, Va.

1854.

BURGHER, JOHN C., 960 Penn Avenue, Pittsburg, Pa.
SISSON, EDWARD R., New Bedford, Mass.
WATSON, WILLIAM H., 270 Genesee Street, Utica, N. Y.

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1855.

FINCKE, BERNHARDT, 122 Livingston Street, Brooklyn, N. Y.
WILDER, LOUIS DEV., 55 W. 33d Street, New York, N. Y.

1857.

BALDWIN, JARED G., 8 E. 41st Street, New York, N. Y.
BECKWITH, SETH R., 135 Prospect Street, East Orange, N. J.
HATCH, PHILO L., 1901 San Pascual Street, Santa Barbara, Cal.

1858.

DETWILER, JOHN J., Easton, Pa.
KELLOGG, EDWIN M., 155 Madison Avenue, New York, N. Y.
VERDI, TULLIO S., 11 Via delle Offcine, Florence, Italy.
WEST, EDWIN, 155 W. 12th Street, New York, N. Y.

1859.

JAMES, BUSHROD W., cor. Green and 18th Streets, Philadelphia, Pa.
JEFFORDS, GEORGE P., Bangor, Me.
ORME, FRANCIS H., 70 N. Forsyth Street, Atlanta, Ga.
PRATT, LESTER M., Homer, N. Y.
SHERMAN, JOHN H., 534 Broadway, Boston, Mass.
SPARHAWK, GEORGE E. E., Burlington, Vt.
WESSELHOEFT, CONRAD, 661 Boylston Street, Boston, Mass.
WESSELHOEFT, W. P., 176 Commonwealth Avenue, Boston, Mass.
WILSON, GROVE H., Meriden, Conn.

1860.

JOHNSTON, ISAAC D., Kennett Square, Pa.
PAYNE, JAMES H., 344 Commonwealth Avenue, Boston, Mass.
SANDERS, JOHN C., 608 Prospect Street, Cleveland, O.
SMITH, T. FRANKLIN, 264 Lenox Avenue, New York, N. Y.
WOOD, ORLANDO S., 521 N. Y. L. Bldg., Omaha, Neb.

1865.

BECKWITH, DAVID H., 528 Prospect Street, Cleveland, O.
KREBS, FRANCIS H., 42 Union Park, Boston, Mass.
RANKIN, JOHN S., Roup and Howe Avenues, Pittsburg, Pa.
WILSON, T. P., Cleveland, O.
ALLEN, TIMOTHY FIELD, 3 E. 48th Street, New York, N. Y.
COGSWELL, CHAS. H., 65 Second Avenue, Cedar Rapids, Ia.
COMSTOCK, T. GRISWOLD, 3401 Washington Avenue, St. Louis, Mo.
DAKE, B. F., 815 Penn Avenue, Pittsburg, Pa.
JAMES, JOHN E., 1521 Arch Street, Philadelphia, Pa.
ROBINSON, SAM'L A., Takoma Park, Washington, D. C.
WETMORE, JOHN MCE., 43 W. 54th Street, New York, N. Y.

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1867.

BAYLIS, BRADFORD L. B., 418 Putnam Avenue, Brooklyn, N. Y.
BELL, JAMES S., 2200 Congress Street, Chicago, Ill.
BROWN, EDWARD V., North Tarrytown, N. Y.
CURRIER, C. B., 921½ Geary Street, San Francisco, Cal.
CUSHING, ALVIN M., 175 State Street, Springfield, Mass.
ERMENTRAUT, JOHN P., 33 7th Street, New York, N. Y.
FISKE, WM. M. L., 484 Bedford Avenue, Brooklyn, N. Y.
FOSTER, WM. D., 420 W. 11th Street, Kansas City, Mo.
GUMBERT, BENJ. B., 840 Franklin Street, Philadelphia, Pa.
HILL, ROBERT L., 553 Albion Street, Oakland, Cal.
JONES, HENRY C., 1220 S. First Avenue, Mount Vernon, N. Y.
KEPP, J. LESTER, 460 Clinton Avenue, Brooklyn, N. Y.
MCCLELLAND, J. H., cor 5th and Wilkins Avenue, Pittsburg, Pa.
MANSON, STEPHEN R., Devall's Bluff, Ark.
MILLER, ROBERT E., Oxford, N. Y.
NEGENDANK, AUGUSTUS, 1112 Washington Street, Wilmington, Del.
PAYNE, FREDERICK, W., cor. Exeter and Boylston Streets, Boston, Mass.
PHILLIPS, ALBERT W., Birmingham, Conn.
PRICE, ELIAS C., 1012 Madison Avenue, Baltimore, Md.
SANFORD, CHARLES E., Bridgeport, Conn.
SAWIN, ISAAC W., 582 Broadway, Providence, R. I.
SCALES, EDWARD P., Newton, Mass.
SHEARER, THOMAS, 345 N. Charles Street, Baltimore, M. D.
THOMPSON, JOHN H., 36 E. 30th Street, New York, N. Y.
THOMPSON, VIRGIL, 56 W. 21st Street, New York, N. Y.
WESSELHOEFT, WALTER, 26 Garden Street, Cambridge, Mass.
WILLARD, LEWIS H., 236 Western Avenue, Allegheny, Pa.

1868.

BANCROFT, WALTON, Keokuk, Ia.
BARROWS, GEORGE S., Marion, Kan.
BAXTER, HARRIS H., 275 Prospect Street, Cleveland, O.
BELL, JAMES B., 178 Commonwealth Avenue, Boston, Mass.
BIGGAR, HAMILTON F., 166 Euclid Avenue, Cleveland, O.
BUDLONG, JOHN C., Providence, R. I.
FINCH, EDWIN W., Center Avenue and Prospect Street, New Rochelle, N. Y.
HEDGES, SAMUEL P., 890 Evanston Avenue, Chicago, Ill.
MACFARLAN, MALCOLM, 1805 Chestnut Street, Philadelphia, Pa.

1869.

ARCULARIUS, PHILIP E., 104 W. 44th Street, New York, N. Y.
BISHOP, HERBERT M., 2627 Hoover Street, Los Angeles, Cal.
BLOSS, JABEZ P., 109 Second Street, Troy, N. Y.
BOWEN, GEORGE W., 232 E. Washington Street, Fort Wayne, Ind.
BOWMAN, BENJAMIN, Chambersburg, Pa.
BRADFORD, THOMAS L., 1862 Franklin Avenue, Philadelphia, Pa.

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BUCK, JIRAH D., 124 W. 7th Street, Cincinnati, O.
COBURN, EDWARD S., 91 Fourth Street, Troy, N. Y.
COMPTON, J. AUGUSTINE, Indianapolis, Ind.
CROSS, HIRAM B., 21 Seavern's Avenue, Jamaica Plain, Boston, Mass.
DENNIS, LABAN, 30 Central Avenue, Newark, N. J.
DUDLEY, PEMBERTON, 1405 N. 16th Street, Philadelphia, Pa.
FLANDERS, DAVID P., Belfast, Me.
GIFFORD, GILBERT L., Hamilton, N. Y.
GRAVES, STOCKBRIDGE P., Saco, Me.
HAYWARD, JOSEPH W., Taunton, Mass.
HOLT, EDWARD B., Lowell, Mass.
HUMPHREY, OTIS M., 392 Wistford Street, Lowell, Mass.
KINNE, THEODORE Y., Paterson, N. J.
KITTINGER, LEONARD, 724 King Street, Wilmington, Del.
MCGEORGE, WALLACE, 521 Broadway, Camden, N. J.
MIDDLETON, MELBOURNE F., 432 Market Street, Camden, N. J.
MORSE, MARTIN V. B., Manchester, N. H.
MOSSMAN, NATHAN A., 28 E. 47th Street, New York, N. Y.
PAYNE, JAMES H., 344 Commercial Avenue, Boston, Mass.
SAGE, WM. H., New Haven, Conn.
SEIP, CHRISTIAN P., 636 Penn Avenue, Pittsburg, Pa.
SMITH, ST. CLAIR, 25 W. 50th Street, New York, N. Y.
SPALDING, HENRY E., 519 Beacon Street, Boston, Mass.
STREETER, JOHN W., 2001 Prairie Avenue, Chicago, Ill.
WOODWARD, ALVIN M., 128 W. 13th Street, New York, N. Y.

1870.

BEEBE, EUGENE W., 173 Wisconsin Street, Milwaukee, Wis.
BETTS, B. FRANK, 1609 Girard Avenue, Philadelphia, Pa.
BOYER, FRANCIS W., Pottsville, Pa.
CHENEY, BENJ. H., 45 Elm Street, New Haven, Conn.
GORDON, GEORGE A., Chillicothe, Mo.
GROSVENOR, LEMUEL C., 185 Lincoln Avenue, Chicago, Ill.
JOHNSON, ROBERT B., Riverside, Cal.
KING, EDWARD H., 906 Fifteenth Street, Denver, Col.
KIPPAX, JOHN R., 3154 Indiana Avenue, Chicago, Ill.
PENNOYER, NELSON A., Kenosha, Wis.
SHELDON, JAY W., 501 Fayette Park, Syracuse, N. Y.
VAN NORMAN, HORACE B., 289 Pearl Street, Cleveland, O.
WOODBURY, WILLIAM H., 22 Central Music Hall, Chicago, Ill.
WOODWARD, ALFRED W., 130 Ashland Avenue, Chicago, Ill.

1871.

ALLEN, RICHARD C., 4419 Frankford Avenue, Philadelphia, Pa.
BALDWIN, AARON, 1205 Eleventh Street, N. W., Washington, D. C.
BINGAMAN, CHAS. F., 922 Penn Avenue, Pittsburg, Pa.
BOWIE, ALONZO P., 87 Main Street, Uniontown, Pa.

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CHURCH, CHARLES A., 128 Prospect Street, Passaic, N. J.
DRAKE, OLIN M., 70 Huntingdon Avenue, Boston, Mass.
EDMUNDSON, WALTER F., 375 Fifth Avenue, Pittsburg, Pa.
FAGER, CHARLES B., 120 Walnut Street, Harrisburg, Pa.
GREENLEAF, JOHN T., Owego, N. Y.
HIGBEE, ALBERT E., Masonic Temple, Minneapolis, Minn.
HIGBEE, CHESTER G., cor. 9th and Robert Streets, St. Paul, Minn.
KNERR, CALVIN B., 1137 Spruce Street, Phliadelphia, Pa.
LEWIS, HENRY M., "Florence," Fourth Avenue and 18th Street, New York.
MARTIN, CONSTANTINE H., Allentown, Pa.
MERCER, ROBERT P., 223 W. 3d Street, Chester, Pa.
MIDDLETON, CALEB S., 1523 Girard Avenue, Philadelphia, Pa.
MITCHELL, JOHN J., Newburgh, N. Y.
SARTAIN, HARRIET J., 212 W. Logan Square, Philadelphia, Pa.
SOUTHWICK, AUGUSTUS B., 107 W. Liberty Street, Rome, N. Y.
STREETS, JACOB G., Bridgeton, N. J.

1872.

ALLEN, HENRY C., 5142 Washington Avenue, Chicago, Ill.
BENDER, PROSPER, Exeter Chambers, Boston, Mass.
BERGHAUS, ALEXANDER, 138 E. 65th Street, New York, N. Y.
DAKE, WILLIAM C., 218 N. Vine Street, Nashville, Tenn.
DOUGHTY, FRANCIS E., 512 Madison Avenue, New York, N. Y.
FULTON, HENRY W., cor. Ripley and Highland Avenues, Pittsburg, Pa.
HUTCHINS, HORACE S., Batavia, N. Y.
MORSE, LUCIUS D., P. O. Box 584, Atlanta, Ga.
OCKFORD, GEORGE M., 3 Oak Street, Ridgewood, N. J.
PETTINGILL, ELIZA F., 300 N. 10th Street, Philadelphia, Pa.
RICHARDSON, BRADBURY M., 151 Milton Street, Brooklyn, N. Y.
SCOTT, CHESTER W., Lawrence, Mass.
WALTER, ZIBA D., 107 W. 7th Street, Pueblo, Col.
WARREN, JOHN K., 68 Pleasant Street, Worcester, Mass.
WILLIAMSON, MATHEW S., 1522 Arch Street, Philadelphia, Pa.
WORCESTER, SAMUEL, 31 Winter Street, Portland, Me.

1873.

ALLEN, GEORGE D., Portland, Mich.
BREYFOGLE, WM. A., 100 Washington Street, Chicago, Ill.
BUFFUM, JOSEPH H., 34 Washington Street, Chicago, Ill.
BUTLER, WILLIAM M., 507 Clinton Avenue, Brooklyn, N. Y.
CANFIELD, CORRESTA T., 106 S. Walnut Street, Pittsburg, Kan.
FISHER, A. LEROY, 315 Pigeon Street, Elkhardt, Ind.
FISHER, CHARLES E., 31 Washington Street, Chicago, Ill.
HITCHCOCK, DEXTER, Norwalk, Conn.
JENNY, WILLIAM H., Broadway and Twelfth Street, Kansas City, Mo.
JONES, GAIUS J., Case Library Building, Cleveland, O.

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LUKENS, MERRIKEN B., 161½ Edgewood Avenue, Atlanta, Ga.
PATCHEN, GEORGE H., 11 E. 59th Street, New York, N. Y.
RUNNELS, ORANGE S., 600 N. Meriden Street, Indianapolis, Ind.
SMITH, CHESTER, Portland, Mich.
VAN NORMAN, EDGAR V., 545 S. Broadway, Los Angeles, Cal.
WARREN, H. ANNA, 817 Bond Street, Dennison, Tex.
WATERS, MOSES H., 126 N. Seventh Street, Terre Haute, Ind.
WILSON, MATHEW T., 1170 Market Street, San Francisco, Cal.

1874.

BAETHIG, HENRY, 350 Pennsylvania Street, Buffalo, N. Y.
BIEGLER, JOSEPH A., 58 S. Clinton Street, Rochester, N. Y.
BOND, MARY E., 122 Lexington Avenue, New York, N. Y.
BOYNTON, FRANK H., 36 W. 50th Street, New York, N. Y.
CAMPBELL, MERRIT B., Patton, Cal.
CRANK, CHAS. D., 106 Auburn Avenue, Cincinnati, O.
EVANS, ALBERT J., Fredonia, N. Y.
FORBES, GEORGE F., 42 William Street, Worcester, Mass.
GREGORY, EDWARD P., Lafayette, near State Street, Bridgeport, Conn.
HALL, ROBERT, 117 Broad Street, Providence R. I.
HERRON, CHARLES D., 3505 Butler Street, Pittsburg, Pa.
HUNT, DWIGHT B., 159 Madison Avenue, New York, N. Y.
KEEP, CAROLINE J. YEOMANS, 308 W. 36th Street, New York, N. Y.
MCDONALD, WILLIAM O., 117 W. 44th Street, New York, N. Y.
MCGAVECK, CLARA PLYMPTON, P. O. Box 346, Nashville, Tenn.
PRATT, EDWIN H., 100 State Street, Chicago, Ill.
WAIT, PHOEBE J. B., Ninth Avenue cor. 34th Street, New York, N. Y.
WALTON, CHARLES E., N. W. cor. Seventh and John Streets, Cincinnati, O.

1875.

BUTLER, CLARENCE W., 35 Fullerton Avenue, S. Montclair, N. J.
CHAPMAN, MILLIE J., 321 Smith Block, Lyeth Street, Pittsburg, Pa.
COWPERTHWAITE, ALLEN C., 31 Washington Street, Chicago, Ill.
DAVIS, FIELDING L., 209 Locust Street, Evansville, Ind.
DESCHERE, MARTIN, 334 W. 58th Street, New York, N. Y.
EVERETT, AMBROSE S., 37 Garrison Avenue, Jersey City, N. J.
GROSS, JAMES ELDRIDGE, 531 La Salle Avenue, Chicago, Ill.
GUERNSEY, JOSEPH C., 1923 Chestnut Street, Philadelphia, Pa.
HASBROUCK, EVERETT, 369 Ninth Street, Brooklyn, N. Y.
HOUSE, ROBERT B., 108 E. High Street, Springfield, O.
JONES, LEONIDAS M., Brooklyn, Mich.
KORNDOERFER, AUGUSTUS, 142 N. 18th Street, Philadelphia, Pa.
MILLER, CHRISTOPHER C., 31 Winder Street, Detroit, Mich.
MITCHELL, JOHN NICHOLAS, 1505 Spruce Street, Philadelphia, Pa.
RUNNELS, MOSES T., 912 Walnut Street, Kansas City, Mo.
SCHLEY, JAMES MONTFORT, 32 W. 49th Street, New York, N. Y.
SHERMAN, LEWIS, 171 Wisconsin Street, Milwaukee, Wis.

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SPINNEY, ANDREW B., Reed City, Mich.
TAYLOR, ESTHER W., 15 E. Cottage Street, Boston, Mass.
TERRY, MARSHALL O., 196 Genesee Street, Utica, N. Y.
THOMAS, CHARLES M., 1623 Arch Street, Philadelphia, Pa.

1876.

ADAMS, REUBEN A., 46 North Fitzhugh Street, Rochester, N. Y.
BEEBE, HENRY E., Sidney, O.
BROWN, ASA W., 27 Burnell Street, Providence, R. I.
CAMPBELL, JAMES A., 1729 Washington Avenue, St. Louis, Mo.
CHASE, HERBERT A., 950 Massachusetts Avenue, Cambridgeport, Mass.
CONANT, THOMAS, Gloucester, Mass.
HINDMAN, DAVID R., Marion, Ia.
JACKSON, EDWARD R., Dubuque, Ia.
JOHNSON, GEORGE H. T., Atchison, Kan.
JOHNSON, MARIA N., 1221 Madison Avenue, Baltimore, Md.
KANOUSE, ABIJAH W., Appleton, Wis.
MERCER, WILLIAM M., 1815 Church Street, Galveston, Tex.
MOHR, CHARLES, 1823 Green Street, Philadelphia, Pa.
MONMONIER, JULIUS L., 480 Classon Avenue, Brooklyn, N. Y.
NICHOLS, AMMI S., 608 DeKum Block, Portland, Ore.
PRICE, EMMOR H., 400 Georgia Avenue, Chattanooga, Tenn.
RICHARDSON, WILLIAM C., 411 Olive Street, St. Louis, Mo.
SLOUGH, FRANK J., Allentown, Pa.
VAN VLECK, PETER H., Sturgis, Mich.
WILLIAMS, NANCY T., Winthrop Court, Augusta, Me.
WILLIAMSON, ALONZO P., 502 Nicollet Avenue, Minneapolis, Minn.
WILSON, JOSEPH H., Bellefontaine, O.

1877

BELLOWS, HOWARD P., cor. Boylston and Berkeley Streets, Boston, Mass.
COUCH, ASA S., Fredonia, N. Y.
DAKE, WALTER M., 218 N. Vine Street, Nashville, Tenn.
LEWIS, F. PARK, 454 Franklin Street, Buffalo, N. Y.
PAINE, N. EMMONS, West Newton, Mass.
PENFIELD, SOPHIA, Danbury, Conn.
VILAS, CHAS. H., 2811 Cottage Grove Avenue, Chicago, Ill.

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ALPHABETICAL LIST OF MEMBERS

The figures placed before the names indicate the date of membership. Names in SMALL CAPITALS are "Senior Members."

Members are requested to inform the General Secretary of any change in their addresses. Those residing in a city are requested to furnish him with their *street* addresses.

Members neglecting to pay their dues for three years, after proper notification from the Treasurer, shall have their names dropped from the roll of membership.—*Article V., Section 4, of the By-Laws.*

1901. Abbott, Edward C., Main Street, Black River Falls, Wis.
1901. Abell, Edmund J., 101 South Centre Street, Joliet, Ill.
1896. Ackerman, James F., 905 Grand Avenue, Asbury Park, N. J.
1896. Adams, Charles, 100 State Street, Chicago, Ill.
1902. Adams, Ernest O., 1617 Wilson Avenue, Cleveland, O.
1899. Adams, Charles F., 229 Union Street, Hackensack, N. J.
1895. Adams, G. Francis, Gowanda, N. Y.
1887. Adams, George Smith, Westboro, Mass.
1895. Adams, H. Alden, 21 W. Ohio Street, Indianapolis, Ind.
1876. ADAMS, REUBEN A., 46 North Fitzburgh Street, Rochester, N. Y.
1899. Adams, Theo. Lewis, 1831 Chestnut Street, Philadelphia, Pa.
1892. Aiken, John Gayle, 1102 St. Charles Avenue, New Orleans, La.
1895. Allard, Frank E., 685 Boylstone Street, Hotel Kensington, Boston.
1895. Allard, Frank E., 373 Commonwealth Avenue, Boston, Mass.
1881. Allen, Albion H., New London, Conn.
1900. Allen, Edward Everett, 385 Main Street, Charlestown, Mass.
1873. ALLEN, GEORGE D, Portland, Mich.
1872. ALLEN, HENRY C., 5142 Washington Avenue, Chicago, Ill.
1902. Aldrich, Stewart W., Grand Avenue, Des Moines, Ia.
1894. Alexander, Ernest L., 1204 N. 24th Street, Omaha, Neb.
1899. Allen, Herbert C., 310 Clermont Avenue, Brooklyn, N. Y.
1899. Allen, J. Wilford, 110 W. 12th Street, New York, N. Y.
1887. Allen, Lamson, 29 Elm Street, Worcester, Mass.
1891. Allen, Paul, 3 E. 48th Street, New York, N. Y.
1871. ALLEN, RICHARD C., 419 Frankford Avenue, Philadelphia, Pa.
1892. Allen, Sarah J., 324 Lawrence Avenue, W., Charlotte, Mich.
1866. ALLEN, TIMOTHY FIELD, 3 E. 48th Street, New York, N. Y.
1901. Alliaume, Charles E., 221 Genesee Street, Utica, N. Y.
1895. Allison, George Freeman, Warren Avenue, East Providence, R. I.
1901. Ambler, John Edgar, 134 E. 19th Street, New York, N. Y.
1894. Ames, Charles S., Ada, Ohio.
1896. Anderson, Jeremiah N., 5 College Street, Toronto, Can.
1893. Anderson, John Wylie, 16 and 17 Steele Block, Denver, Col.
1892. Andrews, William R., Rockville, Md.
1901. Angell, Augustus, 904 Main Street, Hartford, Conn.

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1853. ANGELL, HENRY C., 16 Beacon Street, Boston, Mass.
1901. Angell, Milton H., Salt Point, N. Y.
1899. Aplynne, Guy E., 1214 Main Street, Kansas City, Mo.
1891. Applegate, Grover T., 25 Livingstone Avenue, New Brunswick, N. J.
1899. Appleton, Lucy, 711 Boylston Street, Boston, Mass.
1869. ARCULARIUS, PHILIP E., 52 Chestnut Street, East Orange, N. J.
1902. Armsbury, Aaron B., Marine City, Mich.
1900. Arndt, George O., 123 East High Street, Mt. Vernon, Ohio.
1882. Arndt, Hugo R., 951 Sixth Street, San Diego, Cal.
1902. Arnold, Oliver Henry, 275 Washington Street, Providence, R. I.
1891. Arschagouni, John, 727 Lexington Avenue, New York, N. Y.
1899. Arthur, Alexander Beck, 2039 Spring Garden Street, Philadelphia, Pa.
1897. Arthur, Daniel H., Gowanda, N. Y.
1891. Artz, Jerome L., 3000 Westfield Avenue, Camden, N. J.
1899. Ashcraft, Leon Thomas, 1833 Chestnut Street, Philadelphia, Pa.
1900. Ashley, Maurice C., N. Y. State Hospital, Middletown, N. Y.
1901. Aten, William Henry, 100 Greene Avenue, Brooklyn, N. Y.
1902. Augustin, George William, 469 Third Avenue, Detroit, Mich.
1899. Aurand, Samuel Herbert, 720 Washington Boulevard, Chicago, Ill.
1901. Austin, A. Eugene, 17 E. 66th Street, New York, N. Y.
1894. Austin, Edson C., Elkhorn, Wis.
1901. Averill, Maria Brown, 3145 G Street, San Diego, Cal.
1897. Ayler, Amos E., 125 Washington Street, Green Castle, Ind.
1894. Ayers, Emma F. Macomber, 69 Caroline Street, Saratoga, N. Y.
1896. Ayers, James N., 534 S. Burdick Street, Kalamazoo, Mich.

1891. Babbitt, Zeno B., 12 Iowa Circle, N. W., Washington, D. C.
1897. Babcock, Archibald H., Randolph, N. Y.
1885. Babcock, Daniel A., Fall River, Mass.
1892. Babcock, Francis Lester, 15 Walnut Street, Dedham, Mass.
1896. Babington, John, 62 Miami Avenue, Detroit, Mich.
1901. Bachman, Geo. A., 167 South Avenue, Rochester, N. Y.
1874. BAETHIG, HENRY, 350 Pennsylvania Street, Buffalo, N. Y.
1900. Bagby, George Franklin, 206 East Grace Street, Richmond, Va.
1900. Bagg, Clinton L., 26 West 46th Street, New York, N. Y.
1892. Baier, George Frederick, Norwood, Pa.
1888. Bailey, E. Stillman, 3034 Michigan Avenue, Chicago, Ill.
1901. Bailey, Dewitt P., 507 Chenango Street, Binghamton, N. Y.
1893. Bailey, William M., 25 Miami Avenue, Detroit, Mich.
1887. Baily, Alfred W., 1809 Pacific Avenue, Atlantic City, N. J.
1902. Baker, Albert L., 1400 12th Avenue, Altoona, Pa.
1900. Baker, Daniel J., 1706 North 19th Street, Philadelphia, Pa.
1901. Baker, Harry Burgwyn, 1 E. Grace Street, Richmond, Va.
1902. Baker, Harry H., 710 E. Main Street, Muncie, Ind.
1901. Baker, Harley Nathan, Spring Lake, Mich.
1894. Baker, Jennie Van Holland, 512 Bedford Avenue, Brooklyn, N. Y.
1900. Baker, William Franklin, 2131 East Cumberland Street, Philadelphia, Pa.
1896. Baldinger, Arthur F., 687 The Arcade, Cleveland, O.

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1871. BALDWIN, AARON, 1205 11th Street, N. W., Washington, D. C.
1901. Baldwin, Edward Hill, 77 Clinton Avenue, Newark, N. J.
1892. Baldwin, Henry D., Elyria, O.
1857. BALDWIN, JARED G., 8 E. 41st Street, New York, N. Y.
1899. Ball, Joseph Harris, 301 Crapo Block, Bay City, Mich.
1892. Ballard, Asa N., 2020 Third Avenue, Birmingham, Ala.
1901. Ballard, J. Stow, 610 Hyde Street, San Francisco, Cal.
1899. Balliet, Lorenzo Dow, 1001 Atlantic Avenue, Atlantic City, N. J.
1892. Belyeat, Edmund A., 122 W. Main Street, Kalamazoo, Mich.
1868. BANCROFT, WALTON, Keokuk, Iowa.
1898. Barbee, Benj. Irving, 60 E. Broad Street, Columbus, O.
1888. Barber, Oscar M., Mystic Bridge, Conn.
1901. Barker, Caleb, Jr., Hahnemann Hospital, Park Avenue and 67th Street, New York City.
1881. Barker, Clarence F., Ellis Avenue and Oakwood Boul., Chicago, Ill.
1891. Barnard, Charles A., Centerdale, R. I.
1891. Barnard, James S., 2724 North Charles Street, Baltimore, Md.
1900. Barndt, Milton A., Grand Avenue & 3d Street, Milwaukee, Wis.
1900. Barnes, William Ellsworth, 432 Columbia Road, Boston, Mass.
1894. Barnhill, Tobias G., 208 S. Main Street, Findlay, O.
1901. Barnum, Arthur T., 2524 Collinwood Avenue, Toledo, Ohio.
1868. BARROWS, GEORGE S., Marion, Kan.
1892. Barstow, Benjamin Parker, Kingston, Mass.
1896. Bartholomew, Daniel D., Holly, Mich.
1886. Bartlett, Clarence, 1506 Arch Street, Philadelphia, Pa.
1892. Barton, J. Marcus, Worcester, Mass.
1901. Barton, Pauline Heidet, Rose Building, Cleveland, Ohio.
1901. Baruch, Solomon, 1135 Lexington Avenue, New York, N. Y.
1889. Bascom, Henry M., 728 Columbus Street, Ottawa, Ill.
1880. Bassett, John S., 11 W. 31st Street, New York, N. Y.
1892. Batchelder, Frederick, P., 411 Massachusetts Avenue, Boston, Mass.
1901. Bates, Frank D. W., 34 James Street, North Hamilton, Ont., Can.
1868. BAXTER, HARRIS H., 275 Prospect Street, Cleveland, Ohio.
1867. BAYLIES, BRADFORD L. B., 418 Putnam Avenue, Brooklyn, N. Y.
1902. Beach, Eliza J., 50 Worcester Avenue, Pasadena, Cal.
1896. Beaman, Charles P., Ithaca, N. Y.
1902. Beattie, Joseph Hoyt, Warwick, N. Y.
1889. Becker, Frederick J., Clermont, Iowa.
1888. Becker, Federick J., Postville, Iowa.
1865. BECKWITH, DAVID H., 94 Dorchester Street, Cleveland, O.
1901. Beckwith, Harry M., 304 Barber Building, Joliet, Ill.
1857. BECKWITH, SETH R., 170 Fifth Avenue, New York, N. Y.
1870. BEEBE, EUGENE W., 173 Wisconsin Street, Milwaukee, Wis.
1876. BEEBE, HENRY E., Sidney, Ohio.
1891. Beebe, Wm. B., 197 Fairfield Avenue, Bridgeport, Conn.
1899. Beeler, Margaret Hoper, 1229 N. Tejon Street, Colorado Springs, Colo.
1892. Belden, Charles K., 28 Clinton Avenue, Jamaica, N. Y.
1868. BELL, JAMES B., 178 Commonwealth Avenue, Boston, Mass.
1867. BELL, JAMES S., 2200 Congress Street, Chicago, Ill.
1901. Bell, Willard N., 6 Greene Street, Ogdensburg, N. Y.

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1877. BELLOWS, HOWARD P., 220 Clarendon Street, Boston, Mass.
1899. Belville, Jacob Edgar, 5915 Green Street, Philadelphia, Pa.
1872. BENDER, PROSPER, Exeter Chambers, Boston, Mass.
1881. Bennett, James A., 4 Irving Place, New York, N. Y.
1897. Bennett, John Hillman, 306 High Street, Pawtucket, R. I.
1899. Bennett, Ruth Parker, Lincoln St. and Pacific Ave., Santa Cruz, Cal.
1889. Bennett, William Henry, Fitchburg, Mass.
1888. Bennitt, Francis M., 120 Sumner Avenue, Springfield, Mass.
1899. Benthack, Peter L., Platte Center, Neb.
1846. BERENS, JOSEPH, 1500 Green Street, Philadelphia, Pa.
1899. Bergeron, Emma G., 239 Lenox Ave., New York, and Stamford, Conn.
1872. BERGHAUS, ALEX., 138 E. 65th Street, New York, N. Y.
1892. Bergman, Nils, 400 Collins Street, Joliet, Ill.
1897. Besemer, Howard Burhause, Osborn Block, Ithaca, N. Y.
1893. Besemer, Martin, 116 E. State Street, Ithaca, N. Y.
1890. Best, George B., Englewood, N. J.
1870. BETTS, B. FRANK, 1609 Girard Avenue, Philadelphia, Pa.
1902. Bibighouse, James Russell, 2156 Natrona Street, Philadelphia, Pa.
1874. BIEGLER, JOSEPH A., 58 S. Clinton Street, Rochester, N. Y.
1887. Bier, Peter A., 4200 Butler Street, Pittsburg, Pa.
1901. Bierbauer, Bruno W., 47 Pierrepont Street, Brooklyn, N. Y.
1868. BIGGAR, HAMILTON F., 260 Euclid Avenue, Cleveland, Ohio.
1876. BIGLER, WILLIAM H., 118 N. Seventeenth Street, Philadelphia, Pa.
1898. Billings, Robt. Anderson, Ord, Neb.
1899. Biltner, Albert J., 1036 Hamilton Street, Allentown, Pa.
1871. BINGAMAN, CHAS. F., 922 Penn Avenue, Pittsburg, Pa.
1900. Bingham Anson Holden, 113 W. 87th Street, New York, N. Y.
Street, New York, N. Y.
1892. Bingham, Russell, 62 Day Street, Fitchburg, Mass.
1895. Birch, Charles E., White Plains, N. Y.
1881. Birdsall, Stephen T., Glens Falls, N. Y.
1895. Birdsall, Thomas P., Paterson, N. J.
1869. BISHOP, HERBERT M., 2627 Hoover Street, Los Angeles, Cal.
1899. Bishop, Hudson D., 143 Euclid Avenue, Cleveland, Ohio.
1891. Bishop, William H., 56 W. 48th Street, New York, N. Y.
1853. BISSEL, ARTHUR F., 80 Wall Street, New York, N. Y.
1893. Bissell, Elmer Jefferson, 75 S. Fitzhugh Street, Rochester, N. Y.
1902. Bissell, Fred C., 13 North Main Street, Oberlin, O.
1902. Blackburn, Edwin C., 1421 11th Avenue, Altoona, Pa.
1893. Blackman, George Edwin, Vernon, Tex.
1891. Blackman, Orville B., Dixon, Ill.
1901. Blackman, William W., 519 Clinton Avenue, Brooklyn, N. Y.
1893. Blackwood, Alexander L., 9151 Commercial Avenue, Chicago, Ill.
1902. Blair, Thos. L., Waynesburg, Pa.
1901. Blaine, Wm. M., Youngstown, Ohio.
1894. Blair, William Wightman, 406 Penn Avenue, Pittsburg, Pa.
1896. Blanke, Theodore F., 2239 South Grand Avenue, St. Louis, Mo.
1893. Bliem, Milton J., 425 Navarro Street, San Antonio, Tex.
1887. Blodgett, Stephen H., South Lincoln, Mass.
1869. BLOSS, JABEZ P., 108 Second Street, Troy, N. Y.

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1894. Blouke, Milton, Baker, 1222 W. Washington Street, Chicago, Ill.
1894. Blunt, Arthur W., 323 Fifth Avenue, Clinton, Ia.
1893. Boardman, Edward W., 115 Central Avenue, Parsons, Kan.
1895. Boericke, Felix A., 1011 Arch Street, Philadelphia, Pa.
1883. Boericke, William, 1812 Washington Street, San Francisco, Cal.
1901. Bogardus, Charles S., Clinton, Ill.
1892. Boileau, John D., 804 Lehigh Avenue, Philadelphia, Pa.
1897. Bond, Aaron J., 1 Center Street, Adams, Mass.
1874. Bond, Mary E., 122 Lexington Avenue, New York, N. Y.
1891. Bornmann, Alfred, 271 Putnam Avenue, Brooklyn, N. Y.
1890. Bothfield, James F., 148 Church Street, Newton, Mass.
1896. Bowen Emma Klein, 156 St. Aubirn Avenue, Detroit, Mich.
1869. Bowen, George W., 232 E. Washington Street, Fort Wayne, Ind.
1871. Bowie, Alonzo P., 87 Main Street, Uniontown, Pa.
1869. Bowman, Benjamin, Chambersburg, Pa.
1889. Bowman, Frederick C., 203 Second Avenue, W. Duluth, Minn.
1891. Boyd, John S., New Brighton, Pa.
1870. Boyer, Francis W., Pottsville, Pa.
1901. Boyle, Charles C., 49 W. 37th Street, New York, N. Y.
1874. Boynton, Frank H., 36 W. 50th Street, New York, N. Y.
1894. Brace, Charles C., 1427 Stout Street, Denver, Col.
1900. Bradford, George M., Mt. Morris, Pa.
1869. Bradford, Thomas L., 1862 Frankford Avenue, Philadelphia, Pa.
1898. Bradford, Eli, 632 Eighteenth Street, Rock Island, Ill.
1897. Bragdon, Merritt Caldwell, 1709 Chicago Avenue, Evanston, Ill.
1891. Branin, John W., 33 Washington Street, Mount Holly, N. J.
1895. Branson, Joseph H., 1231 New Jersey Avenue, N. W., Washington, D. C.
1891. Branson, Mary, 1719 Arch Street, Philadelphia, Pa.
1895. Bray, Amanda C., 4 Wellington Street, Worcester, Mass.
1889. Bray, Nicholas, 1140 Main Street, Dubuque, Ia.
1901. Brewer, Mary, 330 E. Chelten Avenue, Germantown, Philadelphia, Pa.
1891. Brewster, Cora B., 1027 Madison Avenue, Baltimore, Md.
1891. Brewster, Flora A., 1221 Madison Avenue Baltimore, Md.
1896. Brewster, Frederick D., 309 Jefferson Avenue, Scranton, Pa.
1901. Brewster, George Franklin, Metropolitan Hospital, Blackwell's Island, New York, N. Y.
1873. Breyfogle, Wm. L., 100 Washington Street, Chicago, Ill.
1890. Brickley, Laura C., Chase and Hamilton Avenues, Cincinnati, O.
1903. Briggs, Joseph Emmons, 206 Huntington Avenue, Boston, Mass.
1889. Briggs, Warren S., Germania Bank Building, St. Paul, Minn.
1903. Brigham, Homer C., 27 Morris Avenue, Grand Rapids, Mich.
1900. Broeser, Henry Valentine, Flower Hospital, Avenue A and 63d Street, New York, N. Y.
1902. Brooks, Caroline Francis, Independence, Ia.
1893. Brooks, William F., Florence, Col.
1899. Brosius, Mary Alice, 1101 K. Street, N. W., Washington, D. C.
1899. Brown, Alice Barlow, 181 Dearborn Avenue, Chicago, Ill.
1876. Brown, Asa W., 27 Burnett Street, Providence, R. I.
1901. Brown, Charles A., 155 Halsey Street, Brooklyn, N. Y.
1891. Brown, Christian H., 1022 Walnut Street, Philadelphia, Pa.

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1899. Brown, Daniel E., 95 Main Street, Brockton, Mass.
1867. Brown, Edward V., North Tarrytown, N. Y.
1898. Brown, Ernest C., corner Second and State Streets, Madrid, Ia.
1893. Brown, Eugene A., 121 E. Washington Avenue, Madison, Wis.
1891. Brown, Grace, Corner 8th and State Streets, Bowling Green, Ky.
1892. Brown, Lucy Henrietta Alice, 420 Westminster Street, Providence, R. I.
1891. Brown, M. Belle, 30 W. Fifty-First Street, New York, N. Y.
1896. Brown, Plumb, 503 State Street, Springfield, Mass.
1898. Brown, Samuel G. A., Lockbox 99, Shippenburg, Pa.
1898. Brown, Stanley R., 287 N. Broad Street, Elizabeth, N. J.
1892. Brown, William K., Box 82 Devon, Pa.
1897. Brownell, De Ette, Memorial Hospital, Brooklyn, N. Y.
1899. Brownell, John Robert, Perry, N. Y.
1899. Bruce, Augustus H., Gardner Building, Utica, N. Y.
1893. Bruce, Ida F., 1156 Springfield Avenue, Irvington, N. J.
1888. Bruce, Orpha D. B., 1302 Florida Avenue, Tampa, Fla.
1899. Brunner, Edgar P., 1108 Spring Garden Street, Philadelphia, Pa.
1894. Bryan, Joseph Harter, 221 Asbury Avenue, Asbury Park, N. J.
1895. Bryant, Edgar Reeve, 406 Sutter Street, San Francisco, Cal.
1894. Bryant, William Cullen, 64 Greene Avenue, Brooklyn, N. Y.
1900. Buchanan, T. Drysdale, 328 W. 24th Street, New York, N. Y.
1869. Buck, Jirah D., 124 W. Seventh Street, Cincinnati, O.
1900. Buckholz, Louise Z., 73 East Eighth Street, New York, N. Y.
1868. Budlong, John C., 604 Westminster Street, Providence, R. I.
1898. Budlong, Martin Salisbury, 604 Westminster Street, Providence, R. I.
1901. Buell, Edwin C., 449 So. Hill Street, Los Angeles, Cal.
1873. Buffam, Joseph H., 34 Washington Street, Chicago, Ill.
1892. Bull, William H. H., Bloomfield, N. J.
1887. Bullard, J. Arthur, Wilkesbarre, Pa.
1902. Burchfield, Samuel Newton, 39 E. Main Street, Titusville, Pa.
1900. Burhman, Ettie Ray, Westboro, Mass.
1891. Burling, J., Summit, N. J.
1899. Burlingame, Frank W., McKeesport, Pa.
1899. Burnham, Norman G., 708 Fourteenth Street, Denver, Col.
1889. Burns, Judson D., Grundy Center, Iowa.
1893. Burr, William Alton, 2010 Welton Street, Denver, Col.
1886. Burritt, Alice, 1129 14th Street, N. W., Washington, D. C.
1899. Burritt, Martha Clark, 313 5th Street, S. E., Washington, D. C.
1883. Burroughs, Amelia, 31 Massachusetts Avenue, Boston, Mass.
1899. Busenbark, Lucy M., The Iliad, Des Moines, Iowa.
1875. Butler, Clarence W., 35 Fullerton Avenue, S. Montclair, N. J.
1873. Butler, William M., 507 Clinton Avenue, Brooklyn, N. Y.
1901. Butman, Emma Willard, 1758 Erie Street, Toledo, Ohio.
1898. Button, Lucius Lucine, 265 Alexander Street, Rochester, N. Y.

1892. Cahill, Eliza B., Westminster, Copley Square, Boston, Mass.
1895. Calderwood, Samuel Herbert, 221 Warren Street, Boston, Mass.
1897. Calhoun, John Charles, 803 Arch Street, Allegheny, Pa.
1899. Cameron, Ida B., 2653 Howard Street, San Francisco, Cal.
1899. Campbell, Duncan, Woodbury, N. J.
1894. Campbell, Eugene, 315 S. Broadway, Los Angeles, Cal.

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1876. CAMPBELL, JAS. A., 206 Mermod-Jaccard Bldg., St. Louis, Mo.
1874. CAMPBELL, MERRITT B., Patton, Cal.
1895. Campbell, Robert Alexander, Ontario, Cal.
1886. Candee, Jas. Willis, 501 Fayette Park, Syracuse, N. Y.
1873. CANFIELD, CORRESTA T., 513½ N. Broadway, Pittsburg, Kan.
1894. Canney, Frederick G., 606 Sutter Street, San Francisco, Cal.
1896. Carleton, Bukk G., 75 W. 50th Street, New York, N. Y.
1889. Carlson, Oscar W., 425 Milwaukee Street, Milwaukee, Wis.
1883. Carmichael, John H., 41 Maple Street, Springfield, Mass.
1891. Carmichael, Thos. H., 7127 Germantown Avenue, Germantown, Philadelphia, Pa.
1896. Caron, George G., 30 Henry Street, Detroit, Mich.
1892. Carpenter, Willard B., 657 N. High Street, Columbus, Ohio.
1891. Carr, Ada, 125 Vreeland Avenue, Paterson, N. J.
1899. Carr, Henry H., Mullica Hill, N. J.
1897. Carter, Rollin Bert, 106 Adolph Avenue, Akron, Ohio.
1897. Carter, Woodward D., 1533 So. 15th Street, Philadelphia, Pa.
1882. Carvill, Alphonso H., 28 Highland Avenue, Somerville Station, Boston, Mass.
1881. Case, Erastus E., 902 Main Street, Hartford, Conn.
1902. Cash, Nathan, 69 Third Street, Uhrichsville, O.
1901. Casselberry, Melville Logan, Morgantown, W. Va.
1898. Cate, Wm. Andrew, Union Blk., Nelson, Neb.
1901. Cauffield, Edwin J., 518 So. Market Street, Akron, Ohio.
1895. Chace, Nathaniel Ray, 89 Touro Street, Newport, R. I.
1897. Chadwick, John Gartside, 382 Franklin Street, Buffalo, N. Y.
1899. Chaffee, John D., Long Beach, Cal.
1891. Chalmers, Robert, 47 Pleasant Street, Woburn, Mass.
1901. Chamberlain, Nelson Hoyt, Macdonough Bldg., Oakland, Cal.
1889. Chamberlin, Myron H., Monrovia, Cal.
1902. Chamblin, Bayles, 2427 N. Grand Avenue, St. Louis, Mo.
1895. Champlin, Henry William, 37 West Main Street, Bloomsburg, Pa.
1899. Champlin, John Garder, Hygeia Hotel, Block Island, R. I.
1891. Chandlee, Henry, 704 W. North Avenue, Baltimore, Md.
1901. Chandler, Jean Christie, 402 Traders' Bldg., Spokane, Wash.
1901. Chandler, Thomas Evans, 13 Sparhawk Street, Brighton, Boston, Mass.
1891. Chandler, Edward, 21 Schermerhorn Street, Brooklyn, N. Y.
1875. CHAPMAN, MILLIE J., 321 Smith Block, Sixth Street, Pittsburg, Pa.
1901. Charles, Emily C., 51 W. 127th Street, New York, N. Y.
1876. CHASE, HERBERT A., 950 Massachusetts Avenue, Cambridge, Mass.
1847. CHASE, HIRAM L., 924 Massachusetts Avenue, Cambridge, Mass.
1899. Chase, J. Oscoe, 214 E. 53d Street, New York, N. Y.
1871. CHASE, MORRIS J., Galesburg, Ill.
1902. Chase, Sherman F., Caro, Mich.
1894. Chase, Theodore Livingstone, 1604 Walnut Street, Philadelphia, Pa.
1870. CHENEY, BENJ. H., 45 Elm Street, New Haven, Conn.
1895. Childs, Helen S., 454 Center Street, Jamaica Plain, Boston, Mass.
1890. Chislet, Howard Roy, 3030 Michigan Avenue, Chicago, Ill.
1891. Choate, Rufus, 3267 O Street, N. W., Washington, D. C.
1898. Christine, Gordon Maxwell, 2043 N. 12th Street, Philadelphia, Pa.

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1891. Church, Aldine B., 102 Huntington Avenue, Boston, Mass.
1871. Church, Charles A., 128 Prospect Street, Passaic, N. J.
1882. Church, Thomas T., 31 Lincoln Avenue, Salem, Ohio.
1900. Churchill, Frederick A., 524 Burke Building, Seattle, Wash.
1881. Clapp, James Wilkinson, 10 Park Square, Boston, Mass.
1896. Clapp, Katherine B., 6222 Woodlawn Avenue, Chicago, Ill.
1801. Clapp, Wesley F., Fairport, N. Y.
1886. Clark, Byron G., 162 West 122d Street, New York, N. Y.
1891. Clark, Charles W., 21 Princess Street, Winnipeg, Manitoba.
1901. Clark, Dwight Freeman, Cook County Hospital, Chicago, Ill.
1901. Clark, Stanley A., Galien, Mich.
1893. Clark, Whitman E., Three Rivers, Mich.
1894. Clarke, Harvey L., Fairbury, Neb.
1888. Clarke, Henry L., 3 Punchard Avenue, Andover, Mass.
1895. Clarke, Mortimer Hall, 221 Auburn Street, Auburndale, Mass.
1901. Clausen, Bernard, 736 Garden Street, Hoboken, N. J.
1901. Clawson, Frank A., New York, N. Y.
1887. Claypool, Albert, 2217 Fulton Street, Fulton, Ohio.
1902. Claypool, John B., 156 Furnace Street, Niles, O.
1889. Clemens, Frank L., 233 West Chestnut Street, Chicago, Ill.
1899. Clingan, Thomas O., 22 Main Street, Niles, Ohio.
1888. Clossen, James H., 53 West Chelten Avenue, Germantown, Philadelphia, Pa.
1900. Cloud, Charles Higginson, 1738 Franklin Street, Philadelphia, Pa.
1890. Cobb, Joseph P., 254 East 47th Street, Chicago, Ill.
1898. Cobb, Sheridan G., 1852 Marshall Avenue, St. Paul, Minn.
1869. Coburn, Edward S., 91 4th Street, Troy, N. Y.
1895. Coffin, John Lambert, 229 Berkeley Street. Boston, Mass
1902. Cogswell, Chas. H., Jr., M. D., Mason City, Iowa.
1902. Cogswell, Charles H., 1011 2d Avenue, Cedar Rapids, Ia.
1900. Colburn, Frederick Wilkinson, 35 Newbury Street, Boston, Mass.
1886. Colby, Edwin A., Gardner, Mass.
1890. Cole, Beder A., West Lima, Wis.
1883. Cole, Edward Z., 1516 Mount Royal Avenue, Baltimore, Md.
1902. Cole, George Harvey, 311 Main Street, Conneaut, O.
1899. Cole, Hurlan Page, 135 Sigourney Street, Hartford, Conn.
1896. Cole, Sarah A., Lincoln, Kan.
1901. Coleman, Daniel E. S., Metropolitan Hospital, Blackwell's Island, New York, N. Y.
1895. Coleman, Ellenwood B., Centre Street, Nantucket, Mass.
1892. Colgrove, Charles H., Willimantic, Conn.
1902. Collins, Allen Bennett, Linesville, Pa.
1901. Collins, Clinton DeWitt, 92 State Street, Chicago, Ill.
1896. Collins, Newton M., 43 East Avenue, Rochester, N. Y.
1899. Colt, Emily S., 2327 Tracy Avenue, Kansas City, Mo.
1895. Colvin, Harvey E., 150 Cherry Street, Burlington, Vt.
1894. Colwell, Charles Estabrook, 23 South Lake Street, Aurora, Ill.
1899. Compton, George W., Ophir, Col.
1869. Compton, J. Augustine, 115 E. Ohio Street, Indianapolis, Ind.

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1866. COMSTOCK, T. GRISWOLD, 3401 Washington Avenue, St. Louis, Mo.
1899. Comstock, William C., 407 N. Charles Street, Baltimore, Md.
1876. CONANT, THOMAS, Gloucester, Mass.
1887. Congdon Adeline B. Dake, M. D., Bakersfield, Cal.
1894. Conklin, Frances C. Donovan, New Brighton, N. Y.
1902. Conklin, Winfield Edwin, 2814 Groveland Avenue, Chicago, Ill.
1898. Connell, Ralph W., 1707 Dodge Street, Omaha, Neb.
1901. Connell, Robert D., 427 E. Long Street, Columbus, Ohio.
1895. Connett, George Cramer, 45 Washington Street, Morristown, N. J.
1902. Conrad, Chas. K., 18 E. Vine Street, Mt. Vernon, O.
1881. Cook, Joseph T., 636 Delaware Avenue, Buffalo, N. Y.
1892. Cook, Mary A., 2113 N. 18th Street, Philadelphia, Pa.
1902. Cook, W. Casper, 501 Bijou Bldg., Pittsburg, Pa.
1886. Cooke, Persifor Marsden, 1290 Race Street, Denver, Col.
1981. Coolidge, John W., 334 Washington Avenue, Scranton, Pa.
1895. Coon, George S., 617 4th Street, Louisville, Ky.
1900. Coon, Marion, Hotel Ilkley, Boston, Mass.
1898. Coons, Henry Newton, 404 East Pearl Street, Lebanon, Ind.
1902. Cooper, Roy Cummings, Bank Bldg., Bellevue, Pa.
1894. Cooper, William Henry, P. O. Box 140, Oakmont, Pa.
1901. Copeland, Elmer H., 70 Elm Street, Northampton Mass.
1892. Copeland, Royal S., 407 N. Ingalls Street, Ann Arbor, Mich.
1900. Corey, Waterman F., 1305 R Street, N. W., Washington, D. C.
1888. Cornell, Albert B., Kalamazoo, Mich.
1902. Cornue, P. W., 9 Washington Street, Ypsilanti, Mich.
1894. Cort, Lottie A., 89 Division Avenue, Brooklyn, N. Y.
1899. Corwin, Elizabeth, 104 Main Street, Binghamton, N. Y.
1892. Costain, Thomas E., 100 State Street, Chicago, Ill.
1899. Cotton, Alonzo A., Vermillion, S. D.
1901. Courtney, John F., 916 Hamilton Street, Lockport, Ill.
1890. Coutant, George F., La Salle, Ill.
1892. Cowell, Joseph H., 301 South Warren Avenue, Saginaw, Mich.
1875. COWPERTHWAITE, ALLEN C., 31 Washington Street, Chicago, Ill.
1897. Cowperthwaite, Joseph Erving, 9, 10, 11 Owsley Block, Butte, Mont.
1894. Cox, Edward Gilbert, 261 State Street, Albany, N. Y.
1894. Cox, Frederick Joseph, 109 State Street, Albany, N. Y.
1895. Cox, George A., 80 S. Swan Street, Albany, N. Y.
1902. Cramer, Norman A., Denver, Colo.
1898. Cramer, Wm. E., 1103 Main Street, Kansas City, Mo.
1878. Cranch, Edward, Erie, Pa.
1874. CRANK, CHAS. D., 106 Auburn Avenue, Cincinnati, Ohio.
1883. Crawford, Alex. K., 406 Sutter Street, San Francisco, Cal.
1898. Crawford, John Martin, Auburn Avenue, Cincinnati, Ohio.
1892. Crawford, Katherine M., 204 E. Market Street, York, Pa.
1896. Crisand, Carl, 2 Charlotte Street, Worcester, Mass.
1893. Crismore, John M., Helena, Sandusky Co., Ohio.
1900. Crichton, Macpherson, 922 14th Street, N. W., Washington, D. C.
1891. Crowther, Isaac, 700 Madison Street, Chicago, Ill.
1895. Crocker, Harry Clinton, Common Street, Providence, R. I.
1899. Cromwell, Lydia Herts, Glen Hall, Atlantic City, N. J.

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1885. Crosby, George W., 716 Atlantic Avenue, Atlantic City, N. J.
1869. Cross, Hiram B., 21 Seavern's Avenue, Jamaica Plain, Boston. Mass.
1901. Crum, Harry Herbert, 212 Hazen Street, Ithaca, N. Y.
1896. Crum, Josephus D., 314 N. Ball Street, Owosso, Mich.
1894. Crumrine, Charles G., 1444-1445 Majestic Building, Detroit, Mich.
1895. Crump, Walter Gray, 693 Madison Avenue, New York, N. Y.
1900. Culin, William Davis, 855 North 41st Street, Philadelphia, Pa.
1902. Cummer, Robt. J., 396 Bolton Avenue, Cleveland, O.
1901. Cummings, Charles S., 40 Oak Street, Middleboro, Mass.
1881. Cummings, M. Louisa, 178a Tremont Street, Boston, Mass.
1901. Cummins, Frank M., Warwick, N. Y.
1892. Curran, Edwin J., Oil City, Pa.
1867. Currier, Christopher B., 921½ Geary Street, San Francisco, Cal.
1897. Curtis, Harry N., 314 2d Street, Marietta, Ohio.
1902. Curtis, Helen Endora, 314 Second Street, Marietta, O.
1894. Cushman, Mary Floyd, Main Street, Castine, Me.
1867. Cushing, Alvin M., 137½ State Street, Springfield, Mass.
1889. Custis, George W. N., 112 E. Capitol Street, Washington, D. C.
1879. Custis, J. B. Gregg, 912 15th Street, N. W., Washington, D. C.
1892. Custis, Marvin A., 634 E. Capitol Street, Washington, D. C.
1898. Cutler, Charles Edward, Magnolia, Iowa.
1900. Cyphers, Edward O., 378 Washington Avenue, Belleville, N. J.

1887. Dake, Adeline B. (Crowley), Bakersfield, Kern Co., Cal.
1866. Dake, Benj. F., Los Angeles, Cal.
1881. Dake, Charles, Hot Springs, Ark.
1887. Dake, Frank B., Hot Springs, Ark.
1872. Dake, William C., 218 N. Vine Street, Nashville, Tenn.
1902. Damon, G. J., Medina, O.
1895. Damon, Newcomb Lincoln, 405 Washington St., Dorchester, Mass.
1879. Danforth, Loomis L., 59 W. 52d Street, New York, N. Y.
1892. Darby, Edward A., Northampton, Mass.
1892. Darby, Margaret G., Northampton, Mass.
1902. Davies, J. Norman, 209 Third St., Warren, Pa.
1901. Davies, Thomas F., 359 W. 116th Street, New York, N. Y.
1899. Davis, Charles A., 1010 15th Street, N. W., Washington, D. C.
1875. Davis, Fielding L., 209 Locust Street, Evansville, Ind.
1899. Davis, Frederick A., 80 Huntington Avenue, Boston, Mass.
1878. Davis, John E. L., 743 Madison Avenue, New York, N. Y.
1892. Davis, John Jefferson, 504 Monument Square, Racine, Wis.
1901. Davis, Oliver Comstock, 323 Jefferson Street, Joliet, Ill.
1899. Davis, Thomas S., 603 Park Avenue, Plainfield, N. J.
1892. Day, George F., 1405 Rhode Island Avenue, Washington, D. C.
1891. Day, Leonidas A. L., 103 State Street, Chicago, Ill.
1887. Deady, Charles, 110 W. 48th Street, New York, N. Y.
1901. Deady, Howard Percy, Liberty, N. Y.
1893. Dean, George A., 1103 Main Street, Kansas City, Mo.
1897. Dean, Louis W., Waterville, N. Y.
1900. Dearborn, Frederick Myers, 146 West 57th Street, New York, N. Y.
1891. Dearborn, Henry M., 146 W. 57th Street, New York, N. Y.

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1893. De Baun, Edwin, 142 Main Avenue, Passaic, N. J.
1902. De Camp, Frank Hurd, 410 William Street, Elmira, N. Y.
1888. Defendorf, John J., Ionia, Mich.
1899. Dehoff, John W., 453 W. Market Street, York, Pa.
1897. Delabarre, Walter E., 222 W. 59th Streeet, New York, N. Y.
1894. Delamater, Nicholas B., 31 Washington Street, Chicago, Ill.
1892. Delap, Silas C., 1214 Main Street, Kansas City, Mo.
1881. Demarest, John H., 59 W. 126th Street, New York, N. Y.
1898. Dennie, George E., 2315 Portland Avenue, Minneapolis, Minn.
1869. Dennis, Laban, 30 Central Avenue, Newark, N. J.
1890. Dennison, Ira Warren, 1312 L Street, N. W., Washington, D. C.
1891. DePuy, Richard G., Jamestown, N. D.
1875. *Deschere, Martin, 334 W. 58th Street, New York, N. Y.
1858. Detwiller, John J., Easton Pa.
1902. Devitt, Frederick Wm., Deep River, Conn.
1901. Devereaux, Jane S., 78 Pleasant Street, Marblehead, Mass.
1889. Dewey, Willis A., Ann Arbor, Mich.
1901. Dickie, Perry, 17 Schermerhorn Street, Brooklyn, N. Y.
1900. Dieffenbach, William H., The Rockingham, S. E. cor. Broadway and 56th Street, New York, N. Y.
1902. Diehel, Wm. H., 505 Mack Street, Detroit, Mich.
1899. Diemar, Lena Hess, 1626 Massachusetts Avenue, Cambridge, Mass.
1893. Dillingham, Thomas Manly, 8 W. 49th Street, New York, N. Y.
1902. Dillman, Daniel, Chippewa Lake, Ohio.
1883. Dillow, Geo. M., "The Rutland," 57th Street and Broadway, New York, N. Y.
1887. Dills, Malcolm, Carlisle, Ky.
1902. Dimon, Robert B., 70 E. Main, Massillon, Ohio.
1878. Dinsmore, Samuel W. S., Sharpsburg, Pa.
1898. Dittmer, Ernest G., Manchester, Iowa.
1887. Docking, Thomas, 164 Boston Avenue, San Diego, Cal.
1892. Dodd, Harry Lee, Chestertown, Md.
1895. Dodge, Charles E., 913 Elm Street, Manchester, N. H.
1902. Dodge, John B., St. Johns, Mich.
1891. Dolan, A. Stanley, Patton, Cal.
1901. Doremus, Widner E., Flower Hospital, Avenue A and 63d Street, New York, N. Y.
1898. Dorris, Alva H., 141 S. 12th Street, Lincoln, Neb.
1872. Doughty, Francis E., 512 Madison Avenue, New York, N. Y.
1895. Dowe, Frank LeC., S. Boulevard and Briggs Ave., New York, N. Y.
1887. Dowling, John W., 116 W. 48th Street, New York, N. Y.
1879. Dowling, Joseph Ivimey, 223 State Street, Albany, N. Y.
1895. Drake, Franklin Joseph, Webster City, Iowa.
1895. Drake, Joseph H., 826 W. 4th Street, Des Moines, Iowa.
1871. Drake, Olin M., 70 Huntington Avenue, Boston, Mass.
1900. Drury, Alfred, 457 West 147th Street, New York, N. Y.
1869. Dudley, Pemberton, 1405 N. 16th Street, Philadelphia, Pa.
1892. Dudley, Perry Hall, 1405 N. 16th Street, Philadelphia, Pa.
1892. Duffield, Alfred Manley, 307 Clinton Street, Huntsville, Ala.

*Deceased since last meeting.

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1899. Duffield, Alice Virginia, 100 State Street, Chicago, Ill.
1900. Duncan, Francis, 100 State Street, Chicago, Ill.
1866. *Duncan, Thomas C., 100 State Street, Chicago, Ill.
1899. Dunham, George Perry, 252 Broadway, Lawrence, Mass.
1895. Dunlevy, Rita, 328 W. 57th Street, New York, N. Y.
1891. Dunn, Charles N., 300 Poplar Street, Centralia, Ill.
1891. Dwinell, Byron L., Taunton, Mass.

1899. Ealer, Percy H., 815 N. 24th Street, Philadelphia, Pa.
1897. Earl, George H., 153 Newbury Street, Boston, Mass.
1891. Eaton, Charles Woodhull, 420 Walnut Street, Des Moines, Iowa.
1893. Eaton, Cora E. Smith, 607 Masonic Temple, Minneapolis, Minn.
1895. Eaton, Samuel Lewis, Newton Highlands, Mass.
1902. Ecki, Simon P., 365 Park Avenue, W., Mansfield, Ohio.
1897. Eddy, Ermina Catharine, 500 William Street, Elmira, N. Y.
1902. Edmunds, Charles W., Sixth and Adams Streets, Bay City, Mich.
1871. Edmundson, Walter F.,1321 Fifth Avenue, Pittsburg, Pa.
1895. Edwards, Franklin W., 26 Hamilton Street, Southbridge, Mass.
1900. Edwards, Laura A., 2669 Douglas Street, Omaha, Neb.
1900. Edwards, Mary L., 19 West 46th Street, New York, N. Y.
1900. Eggleston, Eugene R., 100 North Main Street, Mt. Vernon, Ohio.
1901. Elliot, Amos H., 480 Monroe Street, Brooklyn, N. Y.
1896. Elliott, Frank, Ridge Building, Kansas City, Mo.
1901. Elliott, John Dean, Homœopathic Hospital, Pittsburg, Pa.
1899. Ellis, Kate Walton, 4120 Lake Avenue, Chicago, Ill.
1895. Emerson, Frederick Lincoln, 50 Hancock Street, Dorchester, Mass.
1891. Emerson, Nathaniel Waldo, 685 Boylston Street, Boston, Mass.
1895. Emery, John Taylor Gilman, 27 Main Street, Waterborough, Me.
1900. Emery, William Gordon, 1325 L Street, N. W., Washington, D. C.
1895. Emery, Winifred Newell, 808 Main Street, Waltham, Mass.
1899. Enbanks, William Cicero, 306 Broadway, Paducah, Ky.
1897. Erb, Peter, 32 Palace Arcade, Buffalo, N. Y.
1867. Ermentraut, John P., 44 7th Street, New York, N. Y.
1894. Erni, G. Oscar, 809 E. Spring Street, New Albany, Ind.
1901. Erwin, William, Kenosha, Wis.
1892. Estep, Charles S., Washington, C. H., Ohio.
1874. Evans, Albert J., Fredonia, N. Y.
1892. Evans, Henry J., Fayette and Carey Streets, Baltimore, Md.
1899. Evans, John A., 22 N. Carey Street, Baltimore, Md.
1875. Everett, Ambrose S.
1902. Everett, Edw., 5 E. Main, Madison, Wis.
1901. Everett, Edward A., State Homœopathic Hospital, Middletown, N. Y.
1892. Everett, Frederick, 402 Centre Street, Chicago, Ill.
1891. Everhart, Oliver T., Hanover, Pa.

1893. Fackler, Joshua M., Plymouth, Ohio.
1871. Fager, Charles B., 120 Walnut Street, Harrisburg, Pa.
1882. Fahnestock, Joseph C., Piqua, Ohio.
1901. Farley, William Chase, 117 Haverhill Street, Lawrence, Mass.

* Deceased since last meeting.

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1902. Faust, Frederick A., 21 E. Platt Ave., Colorado Springs, Colo.
1887. Faust, Louis, Schenectady, N. Y.
1901. Faust, William P., 22 Jay Street, Schenectady, N. Y.
1892. Fawcett, John M., 1116 Market Street, Wheeling, W. Va.
1899. Fay, George DeWitt, 23 Bay View Avenue, Atlantic Highlands, N. J.
1894. Fay, Russell P., 165 Warburton Avenue, Yonkers, N. Y.
1890. Fellows, C. Gurnee, 70 State Street, Chicago, Ill.
1892. Fellows, William Edwin, 134 Hammond Street, Bangor, Me.
1901. Fenton, Susan J., 672 14th Street, Oakland, Cal.
1901. Ferree, Judson A., Sidney, Ohio.
1901. Fisher, Arthur, Sherbrooke Street, Montreal, Can.
1868. Finch, Edwin W., Center Avenue and Prospect Street, New Rochelle, N. Y.
1855. Fincke, Bernhardt, 122 Livingston Street, Brooklyn, N. Y.
1888. Finney, Everett B., 1329 N Street, Lincoln, Neb.
1893. Fischbeck, Frederick W., Newport, Ky.
1899. Fischer, John A., 505 Greene Street, Philadelphia, Pa.
1873. Fisher, A. Leroy, 315 Pigeon Street, Elkhart, Ind.
1893. Fisher, Anna M., 412 Nicollet Avenue, Minneapolis, Minn.
1873. Fisher, Charles E., 103 State Street, Chicago.
1899. Fisher, William H., 412 Nicollet Avenue, Minneapolis, Minn.
1895. Fiske, Edwin Rodney, 140 Dean Street, Brooklyn, N. Y.
1867. Fiske, William M. L., 140 Dean Street, Brooklyn, N. Y.
1869. Flanders, David P., Belfast, Me.
1901. Fleagle, Maurice M., 37 York Street, Hanover, Pa.
1891. Fleming, John R., 1903 Pacific Avenue, Atlantic City, N. J.
1901. Fletcher, Zachary P., 23 Cottage Street, Jersey City, N. J.
1881. Flint, Almena P. Barker, 102 Huntington Avenue, Boston, Mass.
1900. Flint, Nellie C., 415 North 52d Avenue, Austin, Ill.
1898. Flower, Frank Warren, Carthage, Mo.
1901. Fobes, Joseph H., 2 Riverview Terrace, New York, N. Y.
1896. Foote, Dellizon A., 216 Paxton Block, Omaha, Neb.
1899. Foote, Theodore, 636 Wood Street, Vineland, N. J.
1901. Foote, William Kellogg, 306 Osgood Street, Joliet, Ill.
1895. Forbes, Charles Holt, 429 School Street, Athol, Mass.
1874. Forbes, George F., 42 Williams Street, Worcester, Mass.
1898. Forbes, Wm. O., 3901 Cottage Grove Avenue, Chicago, Ill.
1895. Forsbeck, Filip A., Birehard Building, 121 Wisconsin Street, Milwaukee, Wis.
1897. Forster, William A., 328 Rialto Building, Kansas City, Mo.
1881. Foss, David, Newburyport, Mass.
1897. Foss, John B., Crete, Neb.
1900. Foster, Herbert W., 27 South Fullerton Avenue, Montclair, N. J.
1880. Foster, Richard N., 553 Jackson Boulevard, Chicago, Ill.
1867. Foster, William D., 420 W. 11th Street, Kansas City, Mo.
1888. Fowler, De Witt C., Aberdeen, S. Dakota.
1901. Francisco, David E., State Hom. Hospital, Middletown, N. Y.
1901. Franklin, Edward D., 325 W. 14th Street, New York, N. Y.
1889. Franklin, William A., M. D., Harvey, Ill.

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1902. Franz, Ernest, Berne, Indiana.
1899. Frazee, Calvin A., Illinois National Bank Building, Springfield, Ill.
1886. Freer, James A., 1523 I Street, N. W., Washington, D. C.
1894. French, Malachi R., 44 East Madison Street, Chicago, Ill.
1902. Frizzell, John W., 61 Central Avenue, Great Falls, Mont.
1901. Frost, Herbert Le, 10 Hayward Street, Cleveland, Ohio.
1896. Frost, William A., Tecumseh, Mich.
1893. Fryer, Winsor F., 26 Oak Street, Middleboro, Mass.
1893. Fulford, George Howard, 233 Phillips Avenue, S., Sioux Falls, S. D.
1885. Fuller, Charles Gordon, 100 State Street, Chicago, Ill.
1895. Fuller, Walter Tracy, 31 Harvard Street, Dorchester, Mass.
1872. Fulton, Henry W., cor. Ripley and Highland Aves., Pittsburg, Pa.
1894. Furman, Horace S., 1705 Tioga Street, Philadelphia, Pa.

1886. Gale, Charles A., Rutland, Vt.
1891. Galloway, William L., 1232 Taylor Avenue, St. Louis, Mo.
1900. Gann, George Willard, Du Bois, Pa.
1901. Ganow, George J., 21 Washington Avenue, Oxford, N. Y.
1899. Gardiner, William G., 158 S. Pennsylvania Avenue, Atlantic City, N. J.
1884. Gardner, Franklin A., 1018 14th Street, N. W., Washington, D. C.
1895. Gardner, Frank Augustine, 23 North Street, Salem, Mass.
1894. Gardner, Henry Seth, 823 Ken Street, Lawrence, Kan.
1899. Garis, Frank A., 220 S. Broad Street, Bethlehem, Pa.
1901. Garnsey, William Smith, 93 N. Main Street, Gloversville, N. Y.
1899. Garrison, Biddle Hiles, 23 Monmouth Street, Red Bank, N. J.
1892. Garrison, John B., 111 E. 70th Street, New York, N. Y.
1900. Garrison, Joseph Sherman, Easton, Md.
1895. Gary, Clara Emerrette, 416 Malborough Street, Boston, Mass.
1902. Gaston, Sarah P., Main Street, Niles, Ohio.
1889. Gatchell, Charles, 100 State Street, Chicago, Ill.
1902. Gault, Wm. Edward, 96 E. Second Street, Portsmouth, Ohio.
1895. Geddes, Annie Lowe, 12 Fullerton Avenue, So. Montclair, N. J.
1881. Geiser, Samuel R., 1511 Baymiller Street, Cincinnati, Ohio.
1901. Gennerich, Charles, 181 E. 64th Street, New York, N. Y.
1891. Geohegan, Wm. A., 918 Hawthorne Ave., Price's Hill, Cincinnati, O.
1896. George, Edgar J., 31 Washington Street, Chicago, Ill.
1894. George, Rebecca Rogers, Ohio and Meriden Streets, Indianapolis, Ind.
1897. George, William E., Ohio and Meriden Streets, Indianapolis, Ind.
1901. Georgi, Sophia E., 1634 Pullan Street, Station A., Cincinnati, O.
1901. Getman, Norman, Richfield Springs, N. Y.
1901. Gibbs, Frank L., 88 W. 2d Street, Chillicothe, Ohio.
1897. Gibson, David M., 241 S. Jefferson Avenue, St. Louis, Mo.
1900. Gibson, Frederick M., 602 Nicollet Avenue, Minneapolis, Minn.
1897. Gifford, Edward F., 1221 W. 8th Street, Erie, Pa.
1869. Gifford, Gilbert L., Hamilton, N. Y.
1879. Gifford, Willis B., Attica, N. Y.
1888. Gilbert, Charles B., 1444 R. I. Avenue, N. W., Washington, D. C.
1899. Gilbert, Chas. E., 323 W. 23d Street, New York, N. Y.
1891. Gilbert, Irwin B., 2027 Columbia Avenue, Philadelphia, Pa.
1899. Gilbert, Wm. Wallace, 314 S. Jefferson Avenue, St. Louis, Mo.

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1894. Gilchrist, James Grant, 215 College Street, Iowa City, Iowa.
1890. Gillard, Edwin, 423 Columbus Avenue, Sandusky, Ohio.
1882. Gilman, John E., Hotel Metropole, 23d Street and Michigan Avenue, Chicago, Ill.
1898. Gilstrap, H. Preston, Washington, Kan.
1902. Ginn, Arba S., 307-8 Federal Bldg., Youngstown, Ohio.
1901. Giren, James B., 463 9th Street, Brooklyn, N. Y.
1891. Givens, Amos Jay, Stamford, Conn.
1895. Gleason, Charles Sherman, Wareham, Mass.
1897. Goddard, John, Jr., 684 Hough Avenue, Cleveland, Ohio.
1891. Godshall, Samuel G., Edge Hill, Pa.
1891. Goff, Ella D., 10 N. Diamond Street, West Allegheny Pa.
1897. Goldsmith, Alfred E., Greenfield, Ohio.
1899. Goodell, Chas. F., 19 E. Patrick Street, Frederick, Md.
1887. Gooding, E. Jeannette, 223 W. Springfield Street, Boston, Mass.
1890. Gooding, Gertrude, Bristol, R. I.
1892. Goodman, Julia, 401 Ross Street, Hamilton, Ohio.
1887. Goodno, William C., 1733 Chestnut Street, Philadelphia, Pa.
1898. Gordon, Arthur Horace, 268 La Salle Avenue, Chicago, Ill.
1870. Gordon, George A., Chillicothe, Mo.
1883. Gorham, George Elmer, 160 Hamilton Street, Albany, N. Y.
1889. Gorton, Frederick T., Portage, Wis.
1899. Goss, Alice Morgan, 606 Sutter Street, San Francisco, Cal.
1892. Gould, Herbert Dearborn, New Boston, N. H.
1890. Gould, William W., Rochelle, Ill.
1902. Graham, Alfred, 270 Woodward Avenue, Detroit, Mich.
1892. Graham, Walter S., Miami, Fla.
1896. Gramm, Theodore J., 846 N. Broad Street, Philadelphia, Pa.
1901. Grant, George D., 16 W. High Street, Springfield, Ohio.
1891. Grant, William H., Pinebluff, N. C.
1892. Graves, Kate I., 5663 Washington Avenue, Chicago, Ill.
1869. Graves, Stockbridge P., Saco, Me.
1881. Green, Charles L., 16 Jackson Street, Providence, R. I.
1898. Green, Julia Minerva, 1738 N Street, N. W., Washington, D. C.
1882. Green, William E., 202 Center Street, Little Rock, Ark.
1871. Greenleaf, John T., Owego, N. Y.
1896. Gregg, Edward R., 334 S. Highland Avenue, Pittsburg, Pa.
1874. Gregory, Edward P., Lafayette, near State Street, Bridgeport, Conn.
1900. Griffin, Judson M., 106 Miami Avenue, Detroit, Mich.
1895. Griffith, Alexander Randall, 763 Wellington Street, Montreal, Can.
1897. Griffith, John B., Lewistown, Pa.
1891. Griffith, Lewis B., 2449 Columbia Avenue, Philadelphia, Pa.
1891. Griffith, William M., 1827 N. 17th Street, Philadelphia, Pa.
1902. Griggs, O. P., 42 Center, Ashtabula, Ohio.
1899. Griscom, L. E., 919 S. 5th Street, Camden, N. J.
1899. Gross, Francis O., 1506 N. 7th Street, Philadelphia, Pa.
1875. Gross, James Eldridge, 222 Schiller Street, Chicago, Ill.
1870. Grosvenor, Lemuel C., 185 Lincoln Avenue, Chicago, Ill.
1897. Grove, Charles E., Hyde Block, Spokane, Wash.
1900. Groves, Charles A., 303 Main Street, East Orange, N. J.

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1899. Grumbrecht, Oscar L., 615 Market Street, Camden, N. J.
1893. Grundmann, J. William, 1000 W. Jefferson Avenue, St. Louis, Mo
1848. GUERNSEY, EGBERT, 180 W. 59th Street, New York, N. Y.
1875. GUERNSEY, JOSEPH C., 1923 Chestnut Street, Philadelphia, Pa.
1867. GUMPERT, BENJ. B., 840 Franklin Street, Philadelphia, Pa.
1893. Gunderlach, Charles H., 3900 Westminster Place, St. Louis, Mo.
1890. Gutherz, Lizzie G., 3689 Olive Street, St. Louis, Mo.
1898. Gwynne, Evan Edmiston, 566 Garfield Avenue, Chicago, Ill.

1901. Hadley, Chas. F., 3320 Federal Street, Camden, N. J.
1899. Haehl, Richard, Alleen Strasse, 23, Stuttgart, Germany.
1901. Haggart, George Benjamin, 153 E. Main Street, Alliance, Ohio.
1901. Haight, Alfred M., 19 N. Broadway, White Plains, N. Y.
1897. Haines, Charles Ter Bush, 43 Gardner Building, Utica, N. Y.
1895. Haines, Oliver Sloane, 137 N. 15th Street, Philadelphia, Pa.
1887. Halbert, Homer V., 70 State Street, Chicago, Ill.
1894. Hall, Matthew J., Mamaroneck, N. Y.
1874. HALL, ROBERT, 60 Cranston Street, Providence, R. I.
1885. Hall, William G., 7th and Edward Streets, St. Joseph, Mo.
1901. Hallett, G. DeWayne, 132 W. 81st Street, New York, N. Y.
1896. Hallman, Victor H., 606½ Central Avenue, Hot Springs, Ark.
1889. Hallock, J. Henry, Saranac Lake, N. Y.
1898. Halphide, Alvan Cavala, 3458 Wabash Avenue, Chicago, Ill.
1886. Halsey, Frederick W., 272 Newbury Street, Boston, Mass.
1893. Halsted, Milton A., Jacksonville, Ill.
1901. Hamblin, Frank Milton, "Glenmary," Owego, N. Y.
1897. Hamlin, Frederick William, 130 W. 48th Street, New York, N. Y.
1897. Hamlin, George Baldwin, Granada, Minn.
1889. Hanchett, Alfred P., 120 4th Street, Council Bluffs, Iowa.
1889. Hanchett, Wm. Henry, Bee Building, Omaha, Neb.
1897. Hancock, Elmer E., 1443 N. 17th Street, Philadelphia, Pa.
1893. Hancock, Joseph, 1639 Columbia Avenue, Philadelphia, Pa.
1902. Handmacher, David, 2260 Broadway, Cleveland, O.
1894. Hann, Lucy Shepard, 109 Bolton Street, Savannah, Ga.
1899. Hansen, Andreas Schantz, Cedar Falls, Iowa.
1901. Hardy, Samuel Oliver, 912 West End Avenue, New York, N. Y.
1897. Hardy, William James, Belmont, N. Y.
1892. Harman, George W., 900 Broad Street, Newark, N. J.
1902. Harrell, M. H., 96 N. Tenth Street, Nashville, Ind.
1897. Harrell, Samuel, N. 10th Street, Noblesville, Ind.
1901. Harris, Nelson A., 339 Union Street, Hackensack, N. J.
1899. Harris, John W., 632 17th Street, Denver, Col.
1882. Harris, W. John, 3514 Lucas Avenue, St. Louis, Mo.
1897. Harrison, Herbert Alexander, Cooperstown, N. Y.
1901. Harter, Frank Dexter, Montpelier, Vt.
1901. Hartley, Arthur, 2109 W. Susquehanna Avenue, Philadelphia, Pa.
1901. Hartley, William Giveans, 335 W. 34th Street, New York, N. Y.
1895. Hartman, W. Louis, "The Kenyon," 601 Warren St., Syracuse, N. Y.
1895. Hasbrouck, Cornelius J., 115 State Street, Bristol, R. I.
1875. HASBROUCK, EVERETT, 389 Fourth Street, Brooklyn, N. Y.

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1887. Hasbrouck, Sayer, 105 Broad Street, Providence, R. I.
1889. Hassell, Samuel E., Lancaster, Wis.
1892. Hassler, J. Wyllis, 1503 Poplar Street, Philadelphia, Pa.
1881. Hassler, William A., 105 N. 8th Street, Allentown, Pa.
1893. Hastings, William C., 28 Downs Block, Seattle, Wash.
1857. HATCH, PHILO L., 1901 San Pascual Street, Santa Barbara, Cal.
1892. Hathaway, Henry Skinner, 146 W. 92d Street, New York, N. Y.
1879. Hawkes, William J., 315 S. Broadway, Los Angeles, Cal.
1900. Hawkins, Ellen F., 31 West College Street, Oberlin, Ohio.
1900. Hawley, Amasa S., Phœnix, Ariz.
1896. Hawxhurst, Howard H., 1333 L Street, N. W., Washington, D. C.
1898. Hayden, Arthur Sumner, Wall Lake, Iowa.
1901. Hays, Emma L. Boice, 2236 Monroe Street, Toledo, Ohio.
1899. Hayward, Abner, 426 Franklin Avenue, Brooklyn, N. Y.
1869. HAYWARD, JOSEPH W., Taunton, Mass.
1895. Haywood, George William, 45 Hanover Street, Lynn, Mass.
1899. Haywood, Julia F., 612 West Avenue, Rochester, N. Y.
1884. Hazard, Theodore Lincoln, 12 N. Clinton Street, Iowa City, Iowa.
1899. Hazeltine, Burton, Y. M. C. A. Building, Evanston, Ill.
1897. Heath, Gertrude Emma, 164 Water Street, Gardiner, Me.
1890. Hedges, Albert P., 754 E. Fullerton Avenue, Chicago, Ill.
1868. HEDGES, SAMUEL P., 890 Evanston Avenue, Chicago, Ill.
1887. Heilner, Herbert Franklin, Burr Building, Scranton, Pa.
1901. Heimbach, Allen E., 125 Sixth Street, Renovo, Pa.
1901. Heimbach, James M., 12 Greeves Street, Kane, Pa.
1897. Helfrich, Charles H., 542 Fifth Avenue, New York, N. Y.
1887. Helmuth, William Tod, 26 E. 62d Street, New York, N. Y.
1896. Hendershott, Lizzie A., Irving, Mich.
1895. Hendy, Clara A., Oak Park, Cook Co., Ill.
1894. Henry, Samuel Dwyer, Excelsior Springs, Mo.
1902. Hendrix, John Oliver, Castle Bldg., Frederick, Md.
1892. Heritage, Alfred C., Jenkintown, Pa.
1899. Heritage, Joseph B., Langhorne, Pa.
1900. Herkimer, George R., Dowagiac, Mich.
1898. Hermann, John, 701 Jackson Street, Sioux City, Iowa.
1874. HERRON, CHARLES D., 3505 Butler Street, Pittsburg, Pa.
1887. Hershberger, Joseph P., 351 E. Main Street, Lancaster, Ohio.
1891. Hetherington, Judson Egbert, 1035 Warren Avenue, Chicago, Ill.
1902. Hewell, W. S., O. S. and S. O. Home, Xenia, Ohio.
1885. Hicks, Susan M., "The Grand," Atlanta, Ga.
1871. HIGBEE, ALBERT E., Masonic Temple, Minneapolis, Minn.
1871. HIGBEE, CHESTER G., 130 Western Avenue, N., St. Paul, Minn.
1901. Hill, Emily L., Gloversville, N. Y.
1901. Hill, George Mortimer, 4700 Grand Boulevard, Chicago, Ill.
1891. Hill, Lucy Chaloner, 492 N. Main Street, Fall River, Mass.
1898. Hill, Marion Jasper, 507 Locust Avenue, Sterling, Ill.
1895. Hill, Noble Hind, 35 Huntington Avenue, Boston, Mass.
1867. HILL, ROBERT L., 553 Albion Street, Oakland, Cal.
1892. Hill, W. Scott, 154 State Street, Augusta, Me.
1899. Hills, Howard B., 31 W. Wood Street, Youngstown, Ohio.

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1902. Hinds, Wm. Henry Weed, 52 Nashua, Milford, N. H.
1876. HINDMAN, DAVID R., Marion, Iowa.
1901. Hinkle, Abbie A., 1039 Maple Avenue, Evanston, Ill.
1896. Hinsdale, Wilbert B., Ann Arbor, Mich.
1891. Hislop, Margaret, 1021 Vermont Avenue, N. W., Washington, D. C.
1873. HITCHCOCK, DEXTER, Norwalk, Conn.
1900. Hobart Austin Walter, 239 N. Penn Avenue, Austin.
1887. Hobart, William F., Leonard, N. D.
1899. Hobson, Sarah Matilda, 5400 Madison Avenue, Chicago, Ill.
1895. Hodgdon, Frank A., 83 Salem Street, Malden, Mass.
1895. Hodge, William H., 324 Buffalo Avenue, Niagara Falls, N. Y.
1902. Hodson, Geo. Stanton, Washington Courthouse, Ohio.
1897. Hœfle, Henry C., 314 Brady Street, Davenport, Iowa.
1892. Hoey, William F., Frederica, Del.
1902. Hoff, Edwin C., Grace Hospital, Detroit, Mich.
1901. Hoffman, James, 461 Jersey Avenue, Jersey City, N. J.
1880. Hofmann, Charles H., 510 S. Highland Avenue, Pittsburg, Pa.
1897. Hollister, Frederick Kellogg, 59 E. 52d Street, New York, N. Y.
1902. Holly, Eugene DeAlton, Owego and Main, Candor, N. Y.
1899. Holmes, Abby Virginia, 1512 S. 29th Street, Omaha, Neb.
1869. HOLT, EDWARD B., Lowell, Mass.
1897. Holton, Charles Smoot, 316 Main Street, Richmond, Ky.
1901. Honan, William Francis, Sherman Square Hotel, Broadway and 71st Street, New York, N. Y.
1893. Honberger, Frank Henry, 360 Oakwood Boulevard, Chicago, Ill.
1894. Hood, C. Todd, 992 W. Adams Street, Chicago, Ill.
1885. Hooker, Edward Beecher, 721 Main Street, Hartford, Conn.
1902. Hoover, Julia E., 145 Taylor St., Cleveland, O.
1889. Hoover, Willis C., Iquique, Chili, S. A.
1896. Hopkins, William T., 65 Broad Street, Lynn, Mass.
1897. Hopkins, William Wilder, 114 Main Street, Geneva, N. Y.
1901. Hopper, Magnus Tate, 46 So. Oxford Street, Brooklyn, N. Y.
1899. Hornby, Mary Stamper, 1 Monadnock Street, Dorchester, Mass.
1883. Horner, J. Richey, 275 Prospect Street, Cleveland, Ohio.
1888. Horning, David W., 604 Pillsbury Building, Minneapolis, Minn.
1902. Horton, Daniel J., Evans, Colo.
1888. Hough, Walter D., 635 Main Street, Niagara Falls, N. Y.
1888. Houghton, Neidhard H., 867 Boylston Street, Boston, Mass.
1899. House, Charles E., 609 W. Tuscarawas Street, Canton, Ohio.
1875. HOUSE, ROBERT B., 108 E. High Street, Springfield, Ohio.
1899. House, Wallace B., 203 W. 113th Street, New York, N. Y.
1901. Houston, Grant, 201 N. Chicago Street, Joliet, Ill.
1899. Howard, Alonzo Gale, 1977 Center Street, W. Roxbury, Mass.
1900. Howard, Clarence C., 57 West 51st Street, New York, N. Y.
1883. Howard, Erving Melville, 401 Linden Street, Camden, N. J.
1881. Howe, J. Morgan, 58 W. 47th Street, New York, N. Y.
1898. Howe, Warren D., 831 Main Street, Canon City, Col.
1889. Howe, Willella, 702 Bush Street, Santa Ana, Cal.
1899. Howlett, George C., Atkinson, Ill.
1901. Hoxie, Albertus Tribue, Porter Block, Grand Rapids, Mich.

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1900. Hoyle, Ethelbert Petrie, 506 Sutter Street, San Francisco, Cal.
1883. Hoyt, Charles, Chillicothe, Ohio.
1901. Hoyt, Eugene F., 39 W. 58th Street, New York, N. Y.
1902. Hoyt, Herbert W., 75 South Fitzhugh Street, Rochester, N. Y.
1896. Hoyt, Mary O., 26 N. 4th Street, Keokuk, Iowa.
1891. Hubbard, Charles H., 425 Broad Street, Chester, Pa.
1901. Hubbell, Adelbert M., 107 Winter Street, Haverhill, Mass.
1894. Hudson, Thomas Howard, 1001 Prospect Avenue, Kansas City, Mo.
1899. Hughes, Charles Wilson, 1407 W. 8th Street, Wilmington, Del.
1888. Humphrey, Frank M., Mamaroneck, N. Y.
1898. Humphrey, Howard M., Lake City, Iowa.
1894. Humphrey, William Armine, 2235 Maplewood Avenue, Toledo, Ohio.
1899. Humphreys, Edward, Somerton, Philadelphia, Pa.
1869. Humphreys, Otis M., 1345 First Avenue, Minneapolis, Minn.
1895. Hunt, Annie W., 217 Washington Street, Providence, R. I.
1892. Hunt, Charles Richard, 474 County Street, New Bedford, Mass.
1874. Hunt, Dwight B., 159 Madison Avenue, New York, N. Y.
1899. Hunt, Ella G., 107 Odd Fellows Temple, Cincinnati, Ohio.
1896. Hunt, John S., Santa Monica, Cal.
1886. Hunt, Maurice P., 200 E. State Street, Columbus, Ohio.
1898. Hurd, Laura B., 1301 Guererro Street, San Francisco, Cal.
1888. Hurd, S. Wright, 73 Main Street, Lockport, N. Y.
1901. Hurlburt, John W., Ohio Street, Uniopolis, Ohio.
1901. Husband, Francis H., 529 Ashmun Street, Sault Ste. Marie, Mich.
1872. Hutchins, Horace S., Batavia, N. Y.
1899. Hutchinson, John, 78 E. 55th Street, New York, N. Y.
1895. Hyde, Louis D., 239 Main Street, Owego, N. Y.

1894. Irvine, Joseph Clinton, Steele Block, Denver, Col.
1897. Irving, Walter W., 121 Wisconsin Street, Milwaukee, Wis.
1893. Irwin, Thomas A., 1234 Liberty Street, Franklin, Pa.
1901. Ives, Nathaniel Holmes, 145 Second Avenue, Mount Vernon, N. Y.

1876. Jackson, Edward R., 855 Locust Street, Dubuque, Iowa.
1900. Jackson, Noah, 125 28th Street, Newport News, Va.
1878. Jackson, William L., 76 Dudley Street, Roxbury, Boston, Mass.
1902. Jacobson, Frank Aikens, 209 Grand Street, Newburg, N. Y.
1859. James, Bushrod W., cor. Green and 18th Streets, Philadelphia, Pa.
1897. James, D. Bushrod, 2005 N. 12th Street, Philadelphia, Pa.
1866. James, John E., 1521 Arch Street, Philadelphia, Pa.
1902. James, Katharine E., 123 N. Main Street, Rockford, Ill.
1891. Janney, O. Edward, 837 N. Eutaw Street, Baltimore, Md.
1886. Jefferds, Henry Clarke, 603 Dekum Building, Portland, Ore.
1859. Jefferds, George P., Bangor, Me.
1899. Jeffrey, George Clinton, 343 Jefferson Avenue, Brooklyn, N. Y.
1902. Jend, Gustav Adolph, 1194 Sayne Ave., Cleveland, Ohio.
1896. Jenkins, Charles G., 224 Washington Avenue, S. Lansing, Mich.
1899. Jenkins, George Hamilton, 139 Main Street, Binghamton, N. Y.
1891. Jenkins, Ralph, 1732 Massachusetts Avenue, N. W., Washington, D. C.
1901. Jenks, Edwin Brown, 300 West Church Street, Elmira, N. Y.
1901. Jenney, Arthur Barker, 38 Franklin Street, Stoneham, Mass.

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1873. JENNEY, WILLIAM H., Broadway and 12th Street, Kansas City, Mo.
1902. Jewett, Howard Clifton, 75 Vine Street, Haverhill, Mass.
1887. Jewitt, Edward H., 484 Arcade, Cleveland, Ohio.
1893. Johns, Emory B., E. 2d Street, Lexington, Ky.
1902. Johnson, Anna, 5115 Liberty Avenue, Pittsburg, Pa.
1893. Johnson, Charles Frederic, 26 Market Street, Newburyport, Mass.
1902. Johnson, Charles Ward, 35 E. Monroe, Jacksonville, Fla.
1893. Johnson, Cora May, Skowhegan, Me.
1876. JOHNSON, GEORGE H. T., Atchison, Kan.
1860. JOHNSON, ISAAC D., Kennett Square, Pa.
1876. JOHNSON, MARIA N., 109 S. Twentieth Street, Philadelphia, Pa.
1870. JOHNSON, ROBERT B., Riverside, Cal.
1890. Johnson, Solomon D., 204 Grand Avenue, Milwaukee, Wis.
1886. Johnson, Theodore M., 200 Susquehanna Avenue, Pittston, Pa.
1896. Johnston, Charles L., 467 Vanderbilt Avenue, Brooklyn, N. Y.
1899. Jones, Everett, 1618 Beacon Street, Brookline, Mass.
1873. JONES, GAIUS J., Caxton Building, Cleveland, Ohio.
1902. Jones, Geo. W., 310 Caxton Bldg., Cleveland, Ohio.
1867. JONES, HENRY C., 1220 S. First Avenue, Mount Vernon, N. Y.
1892. Jones, John J., 1802 Mount Vernon Street, Philadelphia, Pa.
1875. JONES, LEONIDAS M., Brooklyn, Mich.
1898. Jones, Mary Hoffman, Hyde Park, Chicago, Ill.
1902. Jones, W. E., 3859 Page Avenue, St. Louis, Mo.
1899. Jordan, Oscar J., 704 Snyder Avenue, Philadelphia, Pa.
1902. Junkermann, Charles F., 405 N. Broad, Lancaster, Ohio.
1889. Just, August Adolph, Crookston, Minn.
1899. Justice, Harry B., 14 S. 3d Street, Ironton, Ohio.

1896. Kahlke, Charles E., 3034 Michigan Avenue, Chicago, Ill.
1876. Kanouse, Abijah W., Appleton, Wis.
1902. Kapp, Michael Wm., 32 Central Office Bldg., Akron, Ohio.
1893. Karsner, Charles W., 1320 S. Broad Street, Philadelphia, Pa.
1893. Karst, F. August, 636 Sedgwick Street, Chicago, Ill.
1899. Kase, Edmund Harris, 1325 Girard Avenue, Philadelphia, Pa.
1892. Kasselman, Harry Christian, Midway, Ky.
1888. Keegan, William A., 40 Clinton Avenue, S., Rochester, N. Y.
1891. Keeler, Charles B., New Canaan, Conn.
1889. Keeler, E. Elmer, 423 E. Jefferson Street, Syracuse, N. Y.
1900. Keens, Harry E., 647 Main Street, Danville, Va.
1874. KEEP, CAROLINE J. YEOMANS, 308 W. 36th Street, New York, N. Y.
1867. KEEP, J. LESTER, 460 Clinton Avenue, Brooklyn, N. Y.
1898. Kehoe, Henry C., Flemingsburg, Ky.
1892. Kehr, Samuel S., Sterling, Ill.
1897. Keith, Ellen L., Winter Street, Framingham, Mass.
1895. Keith, Horace G., 317 S. Broadway, Yonkers N. Y.
1893. Keith, William E., Porter Building, San Jose, Cal.
1858. KELLOGG, EDWIN M., 155 Madison Avenue, New York, N. Y.
1881. Kennedy, Alonzo L., 286 Newbury Street, Boston, Mass.
1894. Kenyon, Frances Aureola, 865 N. Main Street, Providence, R. I.
1899. Keppel, Frederick D., Owenton, Ky.

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1896. Kerch, Harry E., Dundee, Ill.
1894. Kerr, Harlan T., 105 N. Perry Avenue, Peoria, Ill.
1878. Kershaw, J. Martine, 3421 Washington Avenue, St. Louis, Mo.
1902. Ketchum, Frederick Grant, Postoffice Bldg., Valparaiso, Ind.
1897. Kilgour, Peter Thompson, Hamilton Avenue, College Hill, Cincinnati, Ohio.
1900. Kimmel, Benjamin B., 822 Rose Building, Cleveland, Ohio.
1870. King, Edward H., 729 16th Street, Denver, Col.
1901. King, John B. S., 6713 Wentworth Avenue, Chicago, Ill.
1894. King, Sylvester M., Albia, Iowa.
1897. King, Walter Joel, Golden, Col.
1891. King, William Harvey, 64 W. 51st Street, New York, N. Y.
1888. King, William R., 1422 K Street, N. W., Washington, D. C.
1895. Kingsbury, Edward N., 93 Blackstone Street, Woonsocket, R. I.
1901. Kingsley, Orwin D., 19 N. Broadway, White Plains, N. Y.
1891. Kingsman, Richard, 711 E. Capitol Street, Washington, D. C.
1887. Kinne, Arthur B., 410 Fayette Park, Syracuse, N. Y.
1892. Kinne, Porter S., Paterson, N. J.
1869. Kinne, Theodore Y., Paterson, N. J.
1891. Kinley, Joseph B., 1401 Welton Street, Denver, Co.
1880. Kinyon, Claudius B., Ann Arbor, Mich.
1902. Kinyon, Henry E., 9 Fuller Street, Fullerton, Neb.
1870. Kippax, John R., 3154 Indiana Avenue, Chicago, Ill.
1892. Kirk, Ellen Maria, 169 W. 7th Street, Cincinnati, Ohio.
1893. Kirkland, Edward, Bellows Falls, Vt.
1899. Kistler, Horace Edwin, 313 Main Street, Johnstown, Pa.
1869. Kittinger, Leonard, 411 Deleware Avenue, Wilmington, Del.
1886. Kittinger, Leonard Armor, 411 Delaware Avenue, Wilmington, Del.
1902. Klein, A. Katharine, 172 Bowers Street, Jersey City, N. J.
1899. Kline, Andrew K., Princeton, N. J.
1899. Kline, David C., 5th and Chestnut Streets, Reading, Pa.
1895. Klopp, Henry Irwin, Westboro, Mass.
1901. Knapp, Herbert J., 287 S. 5th Street, Brooklyn, N. Y.
1871. Knerr, Calvin B., 1831 Chestnut Street, Philadelphia, Pa.
1887. Knight, Stephen H., 18 W. Willis Avenue, Detroit, Mich.
1899. Knowlton, Wm. Waldo, 113 S. 16th Street, Philadelphia, Pa.
1896. Koch, Margaret, 1009 University Avenue, S. E., Minneapolis, Minn.
1875. Korndoerfer, Augustus, 1728 Green Street, Philadelphia, Pa.
1897. Korndœrfer, Augustus, Jr., 142 N. 18th Street, Philadelphia, Pa.
1886. Kraft, Frank, 57 Bell Avenue, Cleveland, Ohio.
1897. Krauss, James, 419 Boylston Street, Boston, Mass.
1865. Krebs, Francis H., 42 Union Park, Boston, Mass.
1896. Kreider, Martin K., Goshen, Ind.
1892. Krewson, Amos D., 4613 Paul Street, Frankford, Philadelphia, Pa.
1888. Krogstad, Henry, 1524 K Street, N. W., Washington, D. C.
1899. Krusen, Edward A., Collegeville, Pa.
1899. Kurtz, Alfred J., 1420 S. Broad Street, Philadelphia, Pa.

1894. Laidlaw, George Frederick, 58 W. 53d Street, New York, N. Y.
1887. Laird, Frank F., 315 S. Broadway, Los Angeles, Cal.

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1896. Lance, John D., 21 Broadway, Providence, R. I.
1899. Land, Joseph Foster, 130 W. 126th Street, New York, N. Y.
1901. Lane, Chas. E., 289 Mill Street, Poughkeepsie, N. Y.
1900. Lanning, Willet Scott, Hicksville, Ohio.
1896. Lards, Charles H., 33 Butler Street, Adrian, Mich.
1898. Larkeque, Garrett Bancroft Breckinridge, 345 Main St., Athol, Mass.
1895. Latham, Carrie Augusta, 38 Central Street, Loeminster, Mass.
1899. Laughlin, Thomas Livezey, 527 River Street, Dayton, Ohio.
1894. Lawrence, George W., 5 N. Tejon Street, Colorado Springs, Col.
1885. Lawshe, John Z., 150 W. Peachtree Street, Atlanta, Ga.
1891. Layman, Alfred, 1630 N. 18th Street, Philadelphia, Pa.
1901. Lazarus, Geo. F., 10 Caton Avenue, Brooklyn, N. Y.
1898. Leake, Endell N., 237 W. Sixth Street, Fremont, Neb.
1889. Leal, Malcolm, 107 W. 48th Street, New York, N. Y.
1901. Leao, Francisco Garcia P., 17 State Street, New York, N. Y.
1882. Leavitt, Sheldon, 4665 Lake Avenue, Chicago, Ill.
1899. Lee, George Hyde, 1620 15th Street, N. W., Washington, D. C.
1888. Lee, John Mallory, 121 Lake Avenue, Rochester, N. Y.
1901. Leeds, Frank R., Main Street, Waterville, N. Y.
1901. Leevey, Marian E. Kyle, 513 W. 7th Street, Cincinnati, Ohio.
1890. Lefferts, Franklin P., Belvidere, N. J.
1900. Leib, Edwin Roy, 49 Pleasant Street, Worcester, Mass.
1899. Leipold, William C. A., 3702 Lake Avenue, Chicago, Ill.
1897. Leitch, Robert Newton, Lerna, Ill.
1890. Leland, Aaron G., Whitewater, Wis.
1891. Leland, Clarence H., 202 Merrimack Street, Lowell, Mass.
1896. Lenfestey, John A., 8 S. Gratiot Avenue, Mount Clemens, Mich.
1891. Lentz, Levi R., Fleetwood, Pa.
1882. Leonard, William E., 1809 Portland Avenue, Minneapolis, Minn.
1899. Leopold, H. Preston, 310 Chelten Avenue, Germantown, Pa.
1886. Le Seuer, John Wesley, Batavia, Genesee County, N. Y.
1888. Le Seuer, Oscar, 406 Cass Avenue, Detroit, Mich.
1902. Leslie, Samuel Brewster, Okmulgee, I. T.
1897. Lewis, Frederick Daniel, 188 Franklin Street, Buffalo, N. Y.
1902. Lewis, Fred Lyman, 1854 Pearl Street, Cleveland, Ohio.
1877. Lewis, F. Park, 454 Franklin Street, Buffalo, N. Y.
1871. Lewis, Henry M., "Florence," 18th Street and 4th Avenue, New York, N. Y.
1880. Lewis, Joseph, 330 National Avenue, Milwaukee, Wis.
1899. Lewis, J. Perry, 28th Street and National Avenue, San Diego, Cal.
1899. Lichtenwalner, Abbott B., 2435 N. 7th Street, Philadelphia, Pa.
1893. Light, Jacob Wilbert, Kingman, Kan.
1895. Lines, Mary Louise, 285 Washington Avenue, Brooklyn, N. Y.
1887. Linn, Alexander M., 605 Walnut Street, Des Moines, Iowa.
1893. Linn, Ellis Gregg, Mt. Pleasant, Iowa.
1885. Linnell, E. H., 61 Broadway, Norwich, Conn.
1895. Lippett, Louis David, 41 Pocasset Avenue, Olneyville, R. I.
1893. Llewellyn, Henry S., N. E. c. 5th and Harris Aves., La Grange, Ill.
1893. Loelkes, George, 202 Jackson Street, Belleville, Ill.

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1901. Long, Charles H., Sterry Block, Pontiac, Ill.
1901. Loring, Benjamin Tappan, Massachusetts Homœopathic Hospital, East Concord Street, Boston, Mass.
1900. Lothrop, Edwin S., 807 East Capitol Street, Washington, D. C.
1900. Lounsbery, George, 493 Quarrier Street, Charleston, W. Va.
1899. Low, Joseph H., 2458 Indiana Avenue, Chicago, Ill.
1890. Lowe, Thomas, Slayton, Minn.
1885. Lowenthal, Louis, 1405 W. 103d Street, Chicago, Ill.
1873. LUKENS, MERRIKEN B., 159 Loyd Street, Atlanta, Ga.
1900. Lund, Frederick Albert, 512 Madison Avenue, New York, N. Y.
1896. Lunger, Justus S., E. Water Street, Prospect, Ohio.
1901. Lutze, Frederick Henry, 212 Keap Street, Brooklyn, N. Y.
1897. Luyties, Carl J., 2100 Lafayette Avenue, St. Louis, Mo.
1900. Lyon, George Gaines, Pollock Building, Mobile, Ala.
1902. Lytle, Joseph Allgyer, 718 Rose Bldg., Cleveland, Ohio.
1899. Lyon, Melvern S., 716 Atlantic Avenue, Atlantic City, N. J.
1899. Lyons, Matilda Jamison, Cadiz, Ohio.

1895. Maas, Elizabeth C., 129 N. Main Street, Rockford, Ill.
1895. MacBride, Nathaniel Louis, 158 W. 43d Street, New York, N. Y.
1892. MacCullum, John H., 408 Monroe Avenue, Rochester, N. Y.
1893. MacCracken, Mary E. Avery, 4327 Greenwood Avenue, Chicago, Ill.
1890. MacCracken, William P., 4327 Greenwood Avenue, Chicago, Ill.
1891. MacDonald, Thomas L., 1402 Massachusetts Avenue, N. W., Washington, D. C.
1891. Macfarlan, Duncan, 3924 Chestnut Street, Philadelphia, Pa.
1868. MACFARLAN, MALCOLM, 1805 Chestnut Street, Philadelphia, Pa.
1901. Macfarland, Ralph L., 53 Clinton Avenue, Jamaica, N. Y.
1899. Mackenzie, George W., Somerton, Philadelphia, Pa.
1886. MacLachlin, Daniel A., 1301 Majestic Building, Detroit, Mich.
1898. Macomber, Addison P., Atlantic, Iowa.
1887. Macomber, Henry K., Pasadena, Cal.
1891. Macrum, Charles A., Marquam Block, Portland, Ore.
1901. Macy, Charles Seely, 103 W. 71st Street, New York, N. Y.
1891. Maddux, Daniel P., 8th and Madison Streets, Chester, Pa.
1895. Maeder, John G., 304 E. 120th Street, New York, N. Y.
1898. Mann, Eugene Langdon, 694 Endicott Arcade, St. Paul, Minn.
1901. Mann, George E., Mason, Mich.
1896. Mann, Jesse E., Fonda Block, Louisville, Ky.
1895. Mann, Martha Elizabeth, 2 Commonwealth Avenue, Boston, Mass.
1900. Mann, William O., East Concord Street, Boston, Mass.
1894. Mansfield, Harry Knox, 19 W. Chelton Avenue, Germantown, Philadelphia, Pa.
1881. Mansfield, Job R., 4852 Main Street, Germantown, Philadelphia, Pa.
1900. Marsh, Guy C., 209 So. Market Street, Galion, Ohio.
1901. Marsh, Horatio Richmond, Port Barrow, Alaska.
1892. Marshall, Anna M., 1420 Chestnut Street, Philadelphia, Pa.
1890. Marshall, Robert S., 424 Shady Avenue, Pittsburg, Pa.
1902. Martin, Chas. Velas, 2814 Groveland Avenue, Chicago, Ill.
1871. MARTIN, CONSTANTINE H., Allentown, Pa.

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1893. Martin, Eleanor Frances, 606 Sutter Street, San Francisco, Cal.
1893. Martin, Francis V., 808 Franklin Street, Michigan City, Ind.
1899. Martin, Frederick H., Edgerton, Wis.
1895. Martin, George Albert, Boone, Boone County, Iowa.
1891. Martin, George Forrest, 17 Kirk Street, Lowell, Mass.
1889. Martin, George H., 606 Sutter Street, San Francisco, Cal.
1901. Martin, Harvey H., 710 Jefferson Street, La Porte, Ind.
1891. Martin, Lynn Arthur, 74 Exchange Street, Binghamton, N. Y.
1900. Martin, Robert Wilkie, 1831 Chestnut Street, Philadelphia, Pa.
1892. Martin, Truman J., 245 North Street, Buffalo, N. Y.
1878. Martin, William J., 1712 Carson Street, S., S. Pittsburg, Pa.
1901. Marvin, La Ray, 221 Clay Avenue, Muskegon, Mich.
1901. Mason, Perley Hugh, 734 South Street, Peekskill, N. Y.
1867. Mason, Stephen R., Devall's Bluff, Ark.
1902. Matchett, John, Summerfield, Kas.
1899. Mastin, James William, 25 Eighteenth Avenue, Denver, Col.
1892. Mattson, Alfred Simmons, Moorestown, N. J.
1894. Maurer, Joseph M., 59 W. Wheeling Street, Washington, Pa.
1892. Maxwell, Lewis K., 1615 22d Street, Toledo, Ohio.
1895. May, Geo. Elisha, Institution Avenue and Beacon Street, Newton Centre, Mass.
1887. Maycock, Burt J., 33 Allen Street, Buffalo, N. Y.
1891. Mayer, Charles R., 1032 St. Charles Avenue, New Orleans, La.
1899. McBean, George Martin, 3326 Vernon Avenue, Chicago, Ill.
1902. McBride, Lewis E., 78 Thirteenth St., Franklin, Pa.
1902. McBurney, Benj. A., 200 South Park Avenue, Austin Sta., Chicago.
1901. McCann, T. Addison, 115 N. Perry Street, Dayton, Ohio.
1902. McCauley, E. S. H., Beaver, Pa.
1896. McCauley, John C., 320 Connecticut Street, Rochester, Pa.
1900. McCleary, Joseph Roy, 24 Putnam Street, Marietta, Ohio.
1881. McClellan, David, 104 Clinton Avenue, West Hoboken, N. J.
1867. McClelland, James H., cor. 5th and Wilkins Aves., Pittsburg, Pa.
1879. McClelland, John B., 409 Penn Avenue, Pittsburg, Pa.
1884. McClelland, Robert Watson, cor. 5th and Wilkins Aves., Pittsburg, Pa.
1881. McClure, Eliza Lang, 1919 Wallace Street, Philadelphia, Pa.
1902. McConkey, Thomas Graham, 406 Sutter Street, San Francisco, Cal.
1898. McConnell, Carl Philip, 57 Washington Street, Chicago, Ill.
1896. McCormick, A. Lee, 3110 Woodburn Avenue, Cincinnati, Ohio.
1874. McDonald, William O., 9 W. 68th Street, New York, N. Y.
1886. McDowell, Charles, 110 W. 12th Street, New York, N. Y.
1891. McDowell, George W., 542 Fifth Avenue, New York, N. Y.
1894. McElwee, L. Claude, 1113 N. Grand Avenue, St. Louis, Mo.
1874. McGavock, Clara Plimpton, P. O. Box 346, Nashville, Tenn.
1869. McGeorge, Wallace, 521 Broadway, Camden, N. J.
1901. McGibbon, Walter P., 153 E. 53d Street, Chicago, Ill.
1899. McGranaghan, William H., 220 W. Federal Street, Youngstown, Ohio.
1899. McHarrie, William, Fargo, N. D.
1889. McKinney, Samuel P., 979 Warren Avenue, Chicago, Ill.
1891. McKinstry, Frank P., Washington, N. J.
1901. McKnight, Wm. Clark, 3 Mt. Morris Park West, New York, N. Y.

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1891. McMichael, Arkell R., 969 Madison Avenue, New York, N. Y.
1900. McNeill, Alonzo L., McMinnville, Ore.
1901. Mead, Walter Glover, Deposit, N. Y.
1895. Meade, Stephen Johnson D., 18 W. 7th Street, Cincinnati, Ohio.
1895. Meader, Lee Douglas, 2651 Gilbert Avenue, Walnut Hill, Cincinnati, O.
1891. Means, J. W., Troy, Ohio.
1894. Mellies, Charles, 3825 N. 20th Street, St. Louis, Mo.
1894. Menninger, Charles Frederic, 727 Kansas Avenue, Topeka, Kan.
1891. Mercer, Edward W., 1705 Arch Street, Philadelphia, Pa.
1871. Mercer, Robert P., 223 W. Third Street, Chester, Pa.
1876. Mercer, William M., 1815 Church Street, Galveston, Tex.
1898. Metcalf, Frank A., 47th Street and Kentwood Avenue, Chicago, Ill.
1902. Metcalf, Hiram Hulbert, Chicago, Ohio.
1871. Middleton, Caleb S., 1523 Girard Avenue, Philadelphia, Pa.
1869. Middleton, Melbourne F., 423 Market Street, Camden, N. J.
1894. Miessler, C. F. Otto, Crete, Will County, Ill.
1887. Milbank, William E., 111 State Street, Albany, N. Y.
1889. Miller, Byron E., "The Dekum," Portland, Ore.
1875. Miller, Christopher C., 31 Winder Street, Detroit, Mich.
1895. Miller, Edward Roscoe, 15 Merriman Street, Leominster, Mass.
1902. Miller, Harry T., 113 E. High Street, Springfield, Ohio.
1900. Miller, Irving, 1734 St. Paul Street, Baltimore, Md.
1883. Miller, John, 48 St. John's Place, Buffalo, N. Y.
1899. Miller, Mary Ventnor, Atlantic City, N. J.
1867. Miller, Robert E., Oxford, N. Y.
1898. Miller, Robert P., Evans Block, Oskaloosa, Iowa.
1888. Miller, Zachary T., 2013 Carson Street, Pittsburg, Pa.
1895. Mills, Walter Sands, 154 West 119th Street, New York, N. Y.
1896. Mills, Wesley J., Howell, Mich.
1887. Millsop, Sarah J., 8th and State Streets, Bowling Green, Ky.
1902. Minaker, Andrew J., 291 Valencia Street, San Francisco, Cal.
1900. Miner, Frederick Cohoon, 1134 Forest Avenue, New York, N. Y.
1898. Miner, James B., Charles City, Iowa.
1901. Minor, Mary Euastasia, Burch Avenue, Hyde Park, Cincinnati, Ohio.
1888. Minton, Henry Brewster, 165 Joralemon Street, Brooklyn, N. Y.
1896. Mitchell, Clifford, 70 State Street, Chicago, Ill.
1898. Mitchell, John A., 69 N. 3d Street, Newark, Ohio.
1871. Mitchell, John J., Newburgh, N. Y.
1875. Mitchell, John Nicholas, 1505 Spruce Street, Philadelphia, Pa.
1881. Moffat, Edgar V., 476 Main Street, Orange, N. J.
1881. Moffat, John L., 1136 Dean Street, Brooklyn, N. Y.
1876. Mohr, Charles, Lawnton Avenue, Oak Lane, Philadelphia, Pa.
1876. Monmonier, Julius L., 480 Classon Avenue, Brooklyn, N. Y.
1894. Montgomery, Phineas J., 217 4th Street, Council Bluffs, Iowa.
1891. Montgomery, Richard W., Mamaroneck, N. Y.
1896. Moon, Seymour B., 1314 Eighth Avenue, Beaver Falls, Pa.
1892. Moore, J. Herbert, 1329 Beacon Street, Brookline, Mass.
1898. Moorhead, James, 743 12th Street, Marion, Iowa.
1893. Mordoff, Charles H., Genoa, Ill.
1884. Morgan, William L., 202 W. Franklin Street, Baltimore, Md.

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1890. Morgan, Willis B., 4200 N. Grande Avenue, St. Louis, Mo.
1890. Morley, Frank W., Washington Avenue, Sandusky, Ohio.
1890. Morris, John W., Wheeling, W. Va.
1902. Morris, Wm. Turner, 1407 Chapline Street, Wheeling, W. Va.
1894. Morrison, Frank A., Uhrichsville, Ohio.
1899. Morrow, Emory H., 943 17th Street, Altoona, Pa.
1895. Morse, Chas. W., 98 Washington Street, E. Salem, Mass.
1869. Morse, Martin V. B., Manchester, N. H.
1899. Moseley, George T., 202 Delaware Avenue, Buffalo, N. Y.
1891. Mosher, Mary E., 53 Blue Hill Avenue, Roxbury, Mass.
1899. Moslander, William S., 837 Penn Street, Camden, N. J.
1881. Moss, Mary Denison, 231 Broadway, Providence, R. I.
1869. Mossman, Nathan A., St. Andrew's Hotel, New York, N. Y.
1901. Mowbray, J. Lincoln, 9 Benton Avenue, Walton, N. Y.
1899. Mudge, Katharine G., 309 Essex Street, Salem, Mass.
1896. Mueller, Gustave A., Empire Building, Pittsburg, Pa.
1902. Muhleman, Chas., 611 Market Street, Parkersburg, W. Va.
1901. Muller, Charles Wm., 209 E. 87th Street, New York, N. Y.
1901. Muller, Joseph H., 133 Littleton Avenue, Newark, N. J.
1902. Mukurjee, A. N., Children's Homœopathic Hospital, Philadelphia.
1899. Muncie, Libbie Hamilton, 119 Macon Street, Brooklyn, N. Y.
1892. Munns, Charles O., Oxford, Ohio.
1901. Munson, Edwin Sterling, 16 W. 45th Street, New York, N. Y.
1891. Munson, Milton L., 1503 Pacific Avenue, Atlantic City, N. J.
1901. Murphy, Frank Wellington, 38 So. Ludlow Street, Dayton, Ohio.
1899. Murphy, Sarah A., 727½ 8th Street, Louisville, Ky.
1893. Myers, Amos J., Creston, Iowa.
1895. Myers, Charles E., 170 Green Lane, Manayunk, Philadelphia, Pa.
1901. Myers, Dean W., 345 S. Division Street, Ann Arbor, Mich.

1902. Nash, Eugene B., 28 Clinton Avenue, Courtland, N. Y.
1892. Nead, Will M., 205 State Street, Albany, N. Y.
1867. Negendank, Augustus, 1112 Washington Street, Wilmington, Del.
1893. Neiberger, William Emory, 402 W. Jefferson St., Bloomington, Ill.
1895. Neilson, Howard Stout, 56 W. 48th Street, New York, N. Y.
1899. Nevin, J. Lawrence, 158 Bowers Street, Jersey City, N. J.
1890. Newell, Robert C., 70 State Street, Chicago, Ill.
1895. Newton, Frank Loomis, 147 Highland Avenue, Somerville, Mass.
1897. Newton, John Burnell, Unionville, Conn.
1901. Nicholas, Geo. D., Huron Street Hospital, Cleveland, Ohio.
1876. Nichols, Ammi S., 608 Deckum Block, Portland, Ore.
1880. Nichols, Charles L., 248 Main Street, Worcester, Mass.
1902. Nicholson, Harry Schuyler, 621 Arch Street, Allegheny, Pa.
1886. Nickelson, W. H., A. D. Ripley Block, Adams, N. Y.
1899. Noble, Daniel Cook, Middlebury, Vt.
1902. Nobles, Newmann T. B., 3176 Euclid Avenue, Cleveland, Ohio.
1902. Nobles, Wm. C. E., Main Street, Littleton, N. H.
1893. Norris, Maria Whittelsey, Widdicomb Building, Grand Rapids, Mich.
1889. Norton, Arthur B., 16 W. 45th Street, New York, N. Y.
1887. Norton, Claude R., 700 N. 40th Street, Philadelphia, Pa.

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1881. Nott, Frederick J., 554 Madison Avenue, New York, N. Y.
1889. Nottingham, David M., Lansing, Mich.
1888. Nottingham, John C., 213 Fifth Avenue, Bay City, Mich.
1891. Nowell, John F., Greencastle, Pa.
1895. Noyes, Henry A., Pittsfield, Mass.

1882. Obetz, Henry L., 139 First Street, Detroit, Mich.
1896. O'Brien, Emilie Y., 2504 Nineteenth Street, N. W., Washington, D. C.
1872. Ockford, George M., 3 Oak Street, Ridgewood, N. J.
1889. O'Connor, Joseph T., 7 W. 42d Street, New York, N. Y.
1898. Ogden, Benj. Harvey, Germania Bank Bldg., St. Paul, Minn.
1897. Ogden, Edwin G., 10 E. 32d Street, New York, N. Y.
1884. Olin, Rollin C., 110 Henry Street, W. Detroit, Mich.
1890. Olmstead, Austin F., Green Bay, Wis.
1893. Olmstead, Elmer D., Spokane, Wash.
1895. Opdyke, Levings A., 55 Clinton Avenue, Jersey City, N. J.
1893. Orleman, E. Louise, 32 Bagg Street, Detroit, Mich.
1859. Orme, Francis H., 70 N. Forsyth Street, Atlanta, Ga.
1883. Ormes, Francis D., Jamestown, N. Y.
1901. Osmun, Elmer Douglas, Allegan, Mich.
1876. Ostrom, Homer I., 42 W. 48th Street, New York, N. Y.
1901. Otis, John Calhoun, 319 Mill Street, Poughkeepsie, N. Y.
1900. Overpeck, James W., Third and Dayton Streets, Hamilton, Ohio.
1893. Owen, Charles S., 123 Main Street, Wheaton, Ill.

1881. Packard, Horace, 470 Commonwealth Avenue, Boston, Mass.
1886. Packer, Henry E., 11 Pleasant Street, Woburn, Mass.
1895. Pagan, Frank C., Westerly, R. I.
1890. Paine, Clarence M., 67 N. Forsyth Street, Atlanta, Ga.
1850. Paine, Horace M., 67 N. Forsyth Street, Atlanta, Ga.
1877. Paine, N. Emmons, West Newton, Mass.
1890. Paine, Richard K., Manitowoc, Wis.
1899. Palen, Gilbert J., Main Street and Walnut Lane, Germantown, Pa.
1891. Palmer, Anna Chipman, Houston Avenue, Mattapan, Mass.
1892. Palmer, A. Worrall, The Invernes, 210 W. 57th Street, New York, N. Y.
1899. Palmer, George Henry, 606 Sutter Street, San Francisco, Cal.
1902. Palmer, Harry E., 226 North Main Street, Dayton, Ohio.
1848. Palmer, Miles W., 235 E. 18th Street, New York, N. Y.
1892. Palmer, Owen A., 26 Streator Avenue, Cleveland, Ohio.
1897. Pannebaker, William Milton, 1103 Linden Avenue, Baltimore, Md.
1886. Pardee, Emily V. D., South Norwalk, Conn.
1881. Pardee, Ensign B., 74 W 48th Street, New York, N. Y.
1891. Parker, T. Elwood, Woodbury, N. J.
1896. Parkhurst, Alice S., 1410 Park Avenue, Baltimore, Md.
1883. Parsons, Anson, Springboro, Pa.
1899. Parsons, Clarice Johnston, 177 State Street, Springfield, Mass.
1888. Parsons, Edgar C., Meadville, Pa.
1879. Parsons, Katherine, 914 Prospect Street, Cleveland, Ohio.
1897. Parsons, Thomas, 213 Alexander Street, Rochester, N. Y.
1899. Partridge, Barton Scott, East Bloomfield, N. Y.

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1873. PATCHEN, GEORGE H., 20 W. 59th Street, New York, N. Y.
1900. Paterson, William, 1419 Lorain Street, Cleveland, Ohio.
1899. Patterson, Joseph M., 306 Commerce Building, Kansas City, Mo.
1899. Patton, Arthur Douglas, 58 Crescent Street, Montreal, Canada.
1900. Patton, Charles James, 992 Sherbrooke Street, Montreal, Canada.
1895. Patton, Hugh Matheson, 992 Sherbrooke Street, Montreal, Canada.
1900. Patton, William Mathewson, Marseilles, Ill.
1895. Paul, C. Almon, Solon, Me.
1899. Paul, Willard A., 9 Standish Street, Dorchester, Boston, Mass.
1892. Paul, William Kendall, Belmont, N. Y.
1891. Pauly, Charles A., Union Trust Building, Cincinnati, Ohio.
1899. Paxson, Oliver H., 1733 Arch Street, Philadelphia, Pa.
1899. Payne, Clarence Niles, 385 State Street, Bridgeport, Conn.
1867. PAYNE, FREDERICK W., 100 Boylston Street, Boston, Mass.
1899. Payne, Hannah Jones, 630 Jackson Building, Chicago, Ill.
1869. PAYNE, JAMES H., 344 Commonwealth Avenue, Boston, Mass.
1893. Payne, John Howard, Pierce Building, Copley Square, Boston, Mass.
1901. Peake, Francis, Alexandria, Minn.
1892. Pearson, Mary M., 361 W. Massachusetts Avenue, Boston, Mass.
1895. Pease, Ella Gertrude, 214 Commonwealth Avenue, Boston, Mass.
1899. Peasley, Emma J., 70 Central Street, Somerville, Mass.
1899. Peck, Fred Johnson, 44 Main Street, Ansonia, Conn.
1897. Peck, Frederic W., 42 Park Place, New Britain, Conn.
1879. Peck, George B., 865 N. Main Street, Providence, R. I.
1894. Peck, Grant S., 1427 Stout Street, Denver, Col.
1902. Peck, Harry G., Columbus, Wis.
1900. Peck, John Lyman, 332 Washington Avenue, Scranton, Pa.
1899. Peddicord, Harper, Baltimore, Md.
1877. PENFIELD, SOPHIA, Danbury, Conn.
1870. PENNOYER, NELSON A., Kenosha, Wis.
1887. Percy, Frederick B., Brookline, Mass.
1887. Percy, George Emory, Salem, Mass.
1895. Perkins, Archie Elmer, 82 Day Street, Fitchburg, Mass.
1902. Perkins, Chas. Winfield, Metropolitan Hospital, N. Y.
1884. Perkins, Charles W., 403 Broad Street, Chester, Pa.
1890. Perkins, Ernest D., 1436 Monroe Street, Chicago, Ill.
1899. Perkins, Nathaniel R., 1122 Adams Street, Dorchester, Mass.
1893. Perky, Lenore, 148 S. 12th Street, Lincoln, Neb.
1902. Perry, W. H., Unionville, Mo.
1901. Peterman, Julius H., Ardmore, Ind. Ter.
1900. Peters, Wilson L., Circleville, Ohio.
1898. Peterson, Alfred Cookman, 135 Geary Street, San Francisco, Cal.
1899. Peterson, Pierson B., Honesdale, Pa.
1872. PETTENGILL, ELIZA F., 300 N. 10th Street, Philadelphia, Pa.
1897. Pettet, Isabella Margaretha, 308 E. 15th Street, New York, N. Y.
1899. Pettit, Evelyn Sarah, 1109 Third Avenue, New Brighton, Pa.
1900. Pfeiffer, Harry Shriner, Stamford, Conn.
1901. Phelps, Charles R., Jasper Avenue, Casey, Ill.
1867. PHILLIPS, ALBERT WILLIAM, Birmingham, Conn.
1902. Phillips, Joseph R., 15 East Eighth Street, Erie, Pa.

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1897. Phillips, Lincoln, 1104 McMillan Street, Walnut Hills, Cincinnati, O.
1890. Phillips, R. Oliver, 257 Warburton Avenue, Yonkers, N. Y.
1901. Phillips, William O., Flemingsburg, Ky.
1899. Piatti, Virgil C., Greenwich Avenue, Greenwich, Conn.
1899. Pierce, Oscar F., 846 W. 22d Street, Chicago, Ill.
1891. Pierce, Willard Ide, 64 W. 126th Street, New York, N. Y.
1899. Pierron, Henry J., 438 Greene Avenue, Brooklyn, N. Y.
1893. Pierson, Herman W., 100 State Street, Chicago, Ill.
1901. Pierson, William Horton, 101 McDonough Street, Brooklyn, N. Y.
1901. Pinkham, Charles B., 627½ J Street, Sacramento, Cal.
1900. Pintler, Hiram E., St. Marys, Ohio.
1899. Piper, Fred Smith, Massachusetts Avenue, Lexington, Mass.
1880. Pitcairn, Hugh, Hamburg, Germany.
1902. Plincher, Wm. Allen, 5915 Walker Street, Philadelphia, Pa.
1900. Plumb, Amy E., 913 North Fulton Avenue, Baltimore, Md.
1894. Pollock, Joseph Robert, Fort Worth, Tex.
1885. Pomeroy, Harlan, 116 Ingleside Avenue, Cleveland, Ohio.
1887. Pope, Willis G., Keeseville, N. Y.
1890. Poppele, Charles F., Mount Pulaski, Ill.
1887. Porter, Eugene H., 181 W. 73d Street, New York, N. Y.
1901. Porter, John Guernsey, 404 West Main Street, Clinton, Ill.
1894. Posey, Louis Plumer, 1435 Walnut Street, Philadelphia, Pa.
1899. Potter, Clarence Albert, Gowanda, N. Y.
1899. Powel, Franklin, 241 E. 5th Street, Chester, Pa.
1894. Powel, Milton, 163 W. 76th Street, New York, N. Y.
1888. Powell, William C., Bryn Mawr, Pa.
1901. Powelson, Arthur S., Alexander Street, Rochester, N. Y.
1874. Pratt, Edwin H., 100 State Street, Chicago, Ill.
1900. Pratt, John W., Coatesville, Pa.
1859. Pratt, Lester M., Homer, N. Y.
1891. Pratt, Trimble, Media, Pa.
1898. Prentis, Percy L., Delphos, Iowa.
1891. Price, Eldridge C., 1012 Madison Avenue, Baltimore, Md.
1876. Price, Emmor H., 400 Georgia Avenue, Chattanooga, Tenn.
1892. Prilay, John M., 83 Essex Street, Bangor, Me.
1889. Primm, John W., Woodstock, Ill.
1901. Pulford, William Henry, 88 N. Sandusky Street, Delaware, O.
1902. Pulver, Frank Augustus, 88 Water Street, Torrington, Conn.
1893. Pursell, James Perry, 409 Cornell Bld., Scranton, Pa.
1887. Putnam, William B., 34 Wilder Avenue, Hoosick Falls, N. Y.
1902. Putney, Willis S., Broad Street, Milford, Conn.
1899. Pyle, Harold Ward, 5 W. College Street, Oberlin, O.

1891. Quay, George H., 818 Rose Building, Cleveland, O.
1902. Quilliams, F. F., M. D., 2802 Euclid Ave., Cleveland, Ohio.

1901. Rabe, Rudolph Frederick, 26 Columbus Terrace, Hoboken, N. J.
1893. Raines, Taylor E., 6th and Broadway, Concordia, Kan.
1899. Ramsdell, Oscar Luman, 315½ Mitchell Street, Petoskey, Mich.
1885. Rand, John Prentice, 74 Main Street, Monson, Mass.
1881. Rankin, Egbert G., 226 W. 59th Street, New York, N. Y.

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1902. Rankin, John E., 1185 Dean Street, Brooklyn, N. Y.
1865. RANKIN, JOHN S., cor. Roup and Howe Avenues, Pittsburg, Pa.
1902. Ransom, Eliza Taylor, 373 Commonwealth Ave., Boston, Mass.
1899. Raue, C. Sigmund, 121 N. 10th Street, Philadelphia, Pa.
1896. Rauterberg, Arthur C., 510 5th Street, N. W., Washington, D. C.
1901. Raver, Carl Frost, 806½ J Street, Sacramento, Cal.
1893. Ray, William L., 1214 Main Street, Kansas City, Mo.
1882. Ray, William R., 26 Collins Street, Melbourne, Australia.
1881. Reading, J. Herbert, 1811 Green Street, Philadelphia, Pa.
1888. Reading, Thomas, Hatboro', Pa.
1883. Reddish, Albert W., Sidney, Ohio.
1891. Reed, Clara D. W., 140 Church Street, Newton, Mass.
1885. Reed, Thomas E., Middletown, Ohio.
1894. Rees, Owen, 314 Erie Street, Toledo, Ohio.
1888. Reeves, Joseph M., 1525 Spruce Street, Philadelphia, Pa.
1893. Regan, Milton R., Eureka Springs, Ark.
1898. Reid, John Manley, Main Street, Centerview, Mo.
1896. Reid, Robert G., Union Trust Building, Cincinnati, Ohio.
1900. Reilly, John Armstrong, Fulton, Mo.
1897. Reilly, Walter E., Fulton, Mo.
1897. Reilly, William F., 1030 Madison Avenue, Covington, Ky.
1899. Reinhold, Hannah C., 761 W. 4th Street, Williamsport, Pa.
1893. Reininger, Edward C., 353 Oakley Boulevard, Chicago, Ill.
1898. Remington, Fred. A., Sioux City, Iowa.
1883. Renninger, John S., Marshall, Minn.
1901. Renwick, Ward J., 102 Goff Street, Auburn, Me.
1901. Reynolds, John N., Grand Haven, Mich.
1891. Reynolds, Warren U., 320 Manhattan Avenue, New York, N. Y.
1897. Rice, Alvin B., 117 Fairmount Avenue, Jamestown, N. Y.
1895. Rice, George Brackett, 220 Clarendon Street, Boston, Mass.
1899. Rice, Harry Edwin, Exeter Chambers, Springfield, Mass.
1892. Rice, Marvin S., Aurora, Ill.
1886. Richards, George E., 44½ Bellevue Place, Chicago, Ill.
1891. Richards, George Herbert, 30 Highland Avenue, Orange, N. J.
1887. Richards, Llewellyn B., Oswego, N. Y.
1890. Richardson, Andrew J., 39 E. 83d Street, New York, N. Y.
1872. RICHARDSON, BRADBURY M., 151 Milton Street, Brooklyn, N. Y.
1895. Richardson, Edward Blake, Rochester, Vt.
1900. Richardson, Francis Newton, 83 Jennings Avenue, Cleveland, Ohio.
1886. Richardson, Frank C., 685 Boylston Street, East Boston, Mass.
1897. Richardson, George Henry, care S. A. K., Patton, Cal.
1891. Richardson, George W., 138 E. 79th Street, New York, N. Y.
1893. Richardson, Oscar K., 303 Masonic Temple, Minneapolis, Minn.
1876. Richardson, William C., 411 Olive Street, St. Louis, Mo.
1899. Richert, Peter, Goessel, Kan.
1891. Ricker, Marcena S., 58 Lorimer Street, Rochester, N. Y.
1883. Ridge, Jonathan T., 1617 N. 7th Street, Philadelphia, Pa.
1901. Ridgeway, Mary Davis, 5336 Wayne Avenue, Philadelphia, Pa.
1897. Rieger, Joseph, 9 W. 4th Street, Dunkirk, N. Y.
1887. Riggs, Daniel H., 1410 11th Street, N. W., Washington, D. C.

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1902. Riley, C. T., New Matamoras, O.
1893. Ripley, George H., Kenosha, Wis.
1889. Ripley, Martha G., 40 South 10th Street, Minneapolis, Minn.
1899. Ritch, Orando S., 337a Macon Street, Brooklyn, N. Y.
1899. Rittenhouse, Jacob S., 38 S. Fourth Street, Reading, Pa.
1902. Rizer, Alfred L., 318 No. Cleve Avenue, Canton, O.
1897. Roberts, Arthur Augustine, Wellsburg, W. Va.
1891. Roberts, Charles Wesley, 638 Washington Avenue, Scranton, Pa.
1892. Roberts, David J., New Rochelle, N. Y.
1901. Roberts, Dwight J., 912 Venetian Building, Chicago, Ill.
1881. Roberts, George F., 604 Pillsbury Building, Minneapolis, Minn.
1892. Roberts, George Watson, 170 W. 59th Street, New York, N. Y.
1900. Roberts, Oscar Waldo, 24 Thompson Street, Springfield, Mass.
1890. Roberts, Susan A., Downer's Grove, Ill.
1901. Roberts, William Burchard, Pillsbury Building, Minneapolis, Minn.
1897. Robertson, Herbert Miller, Arlington, Riverside County, Cal.
1902. Robbins, A. Jerome, Mayville and Chautauqua, N. Y.
1900. Robinson, Clarence G., Jeannette, Pa.
1891. Robinson, Franklin E., Carthage, N. Y.
1899. Robinson, Nathaniel, 89 Halsey Street, Brooklyn, N. Y.
1866. Robinson, Samuel A., Takoma Park, Washington, D. C.
1893. Roby, George F., Penacook, N. H.
1899. Rockwell, Alfred E. P., 248 Main Street, Worcester, Mass.
1890. Rockwell, Cortland B., 5401 Madison Avenue, Chicago, Ill.
1881. Rockwell, John A., Box 104, Harriman, Tenn.
1899. Rockwell, John Arnold, Jr., 26 Garden Street, Cambridge, Mass.
1902. Rogers, Jesse Belmont, 118 E. Sixth Street, Michigan City, Ind.
1886. Rollins, Charlotte A., Chelsea, Mass.
1897. Rolston, Rose Amanda, 52 High Street, Warren, Ohio.
1901. Roper, Frederick Eugene, 73 Broad Street, New York, N. Y.
1901. Roper, Pulaski B., 822 Rose Building, Cleveland, Ohio.
1882. Rosenberger, Abraham S., Covington, Ohio.
1895. Ross, Alice Idella, Whittier, Iowa.
1900. Rossiter, Edwin B., 3 High Street, Pottstown, Pa.
1886. Rounsevel, C. Sedgwick, 211 Main Street, Nashua, N. H.
1902. Rowland, Justin E., South Euclid, O.
1891. Royal, George, 505 Walnut Street, Des Moines, Iowa.
1897. Royal, T. Cook, 101 Milton Avenue, Ballston Spa, N. Y.
1897. Rudderow, Edward Douglas, 145 W. 88th Street, New York, N. Y.
1890. Rumsey, Charles Leslie, 812 Park Avenue, Baltimore, Md.
1875. Runnels, Moses T., 912 Walnut Street, Kansas City, Mo.
1873. Runnels, Orange S., 203 N. Meriden Street, Indianapolis, Ind.
1887. Runnels, Sollis, 38 E. Ohio Street, Indianapolis, Ind.
1880. Rushmore, Edward, Plainfield, N. J.
1880. Russegue, Henry E., 93 Farmington Avenue, Hartford, Conn.
1901. Russell Antoinette E. C., 5348 Wayne Avenue, Germantown, Philadelphia, Pa.
1890. Russell, Henry A., West Superior, Wis.
1892. Russell, H. Everett, 30 E. 74th Street, New York, N. Y.

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1901. Russell, Walter E., 25 East Main Street, Walla Walla, Wash.
1890. Rust, Edwin G., 29 Euclid Avenue, Cleveland, Ohio.

1892. Sage, Henry P., 48 Howe Street, New Haven, Conn.
1869. SAGE, WILLIAM H., 48 Howe Street, New Haven, Conn.
1899. Sager, Cyril Wickfield, 108 W. Main Street, Titusville, Pa.
1901. St. John, Arthur H., Walton, N. Y.
1894. Salisbury, Samuel Scott, Bradbury Building, Los Angeles, Cal.
1896. Sanborn, Emma M. E., 4 Morton Street, Andover, Mass.
1900. Sandel, John H., Plymouth, Pa.
1860. SANDERS, JOHN C., 608 Prospect Street, Cleveland, Ohio.
1884. Sanders, J. Kent, 608 Prospect Street, Cleveland, Ohio.
1890. Sanders, Orren B., 358 Commonwealth Avenue, Boston, Mass.
1867. SANFORD, CHARLES E., Bridgeport, Conn.
1895. Sanger, Henry Mortimer, 1040 Westminster Street, Providence, R. I.
1902. Sankey, B. E., 56 S. Jefferson Street, New Castle, Pa.
1871. SARTAIN, HARRIET J., 212 W. Logan Square, Philadelphia, Pa.
1867. SAWIN, ISAAC W., 580 Broadway, Providence, R. I.
1890. Sawtelle, Benjamin A., Norfolk, Conn.
1902. Sawers, Frank C., 5208 Second Avenue, Pittsburg, Pa.
1893. Sawyer, Charles E., Marion, Ohio.
1898. Sawyer, Eugene W., 1416 Masonic Temple, Chicago, Ill.
1899. Sawyer, Willis Herbert, The Peabody, Ashmont St., Boston, Mass.
1867. SCALES, EDWARD P., Newton, Mass.
1901. Scarborough, Charles W., 19 Wilmer Place, Madison, N. J.
1901. Schall, John H., 141 St. Marks Avenue, Brooklyn, N. Y.
1892. Schantz, M. Margaret Hassler, 402 N. 5th Street, Reading, Pa.
1902. Schell, Samuel U., 110 N. Third Street, Hamilton, O.
1894. Schenck, Herbert Dana, 241 McDonough Street, Brooklyn, N. Y.
1875. SCHLEY, JAMES MONTFORT, 32 W. 49th Street, New York, N. Y.
1902. Schlesselman, Jno. Theodore, Good Thunder, Minn.
1879. Schneider, Adolph Benedict, 520 Rose Building, Cleveland, Ohio.
1894. Schneider, S. Newton, 236 Dearborn Avenue, Chicago, Ill.
1899. Schollenberger, Lewis A., 637 Walnut Street, Reading, Pa.
1898. Schoor, Edward, Garden City, Mo.
1892. Schulze, Carl Andrew, 49 E. Main Street, Columbus, Ohio.
1891. Schumann, Carl, Delhi, N. Y.
1891. Schwenk, Clayton S., 1319 Jefferson Street, Philadelphia, Pa.
1872. SCOTT, CHESTER W., Lawrence, Mass.
1895. Scott, Cyrus W., 90 Main Street, Andover, Mass.
1886. Scott, William H., 104 W. 44th Street, New York, N. Y.
1901. Seaman, Clayton Welch, 232 Hoyt Street, Buffalo, N. Y.
1902. Sears, Albert H., 139 W. Ninth Street, Anderson, Ind.
1901. Seibert, Walter W., 43 N. 4th Street, Easton, Pa.
1891. Seibert, William A., Easton, Pa.
1897. Seip, Charles Lewis, 299 Union Street, New Bedford, Mass.
1869. SEIP, CHRISTIAN P., 636 Penn Avenue, Pittsburg, Pa.
1895. Seitz, William Clinton, Glen Rock, Pa.
1902. Sellew, Sylvester Wolcott, 17 Center Street, Oil City, Pa.
1897. Seward, Frederick W., Main Street, Goshen, Orange County, N. Y.

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1900. Seward, Frederick W., Jr., Goshen, N. Y.
1894. Seward, John Perry, 200 W. 70th Street, New York, N. Y.
1901. Seymour, Geo. W., 40 North Portage Street, Westfield, N. Y.
1847. SHACKFORD, RUFUS, Portland, Me.
1899. Shallcross, Isaac G., 1617 Arch Street, Philadelphia, Pa.
1902. Shannon, Elmer Ellsworth, Ivoryton, Conn.
1879. Shannon, Samuel F., Jacobson Building, Denver, Col.
1901. Schreiner, Emma T., 190 Maplewood Avenue, Germantown, Philadelphia, Pa.
1902. Sharp, John R., Homœopathic Hospital, Washington, D. C.
1894. Shaw, John Cook, 23 S. Sixth Street, New Bedford, Mass.
1895. Shaw, John Joseph, 14 Brewster Street, Plymouth, Mass.
1867. SHEARER, THOMAS, 345 N. Charles Street, Baltimore, Md.
1890. Shearer, Thomas L., 345 N. Charles Street, Baltimore, Md.
1882. Shears, George F., 3130 Indiana Avenue, Chicago, Ill.
1870. SHELDON, JAY W., 501 Fayette Park, Syracuse, N. Y.
1893. Shellenberger, Charles Nell, 1831 Wallace Street, Philadelphia, Pa.
1886. Shelton, George G., 521 Madison Avenue, New York, N. Y.
1895. Shepard, George Andrew, "The Glenmore," 7th Ave. & 55th St., N. Y.
1889. Shepard, William A., Colorado Springs, Col.
1859. SHERMAN, JOHN H., 534 Broadway, Boston, Mass.
1899. Sherman, James Turner, 29 Virginia Street, Boston, Mass.
1901. Sherman, Le Roy B., 355 W. 14th Street, New York, N. Y.
1875. SHERMAN, LEWIS, 171 Wisconsin Street, Milwaukee, Wis.
1889. Sherman, Nancy B., 700 Massachusetts Ave., N. E., Washington, D. C.
1897. Sherwood, Bradford Wykoff, 1117 S. Salina Street, Syracuse, N. Y.
1882. Sherwood, Herbert A., Warren, Ohio.
1899. Shinn, Charles T., 17 E. Penn Street, Norristown, Pa.
1901. Shipman, Thos. Harris, 281 Benefit Street, Providence, R. I.
1900. Shirk, Samuel Martin, 35 Sumner Street, Stamford, Conn.
1898. Shoemaker, Chas. A., 1117 L Street, Lincoln, Neb.
1899. Shoemaker, Daniel W., 1924 Green Street, Philadelphia, Pa.
1899. Short, Zuber N., 428 Central Avenue, Hot Springs, Ark.
1899. Shower, George T., 421 Roland Avenue, Baltimore, Md.
1891. Shreve, Joseph, 6 West Union Street, Burlington, N. J.
1902. Shuffleton, Frank A., 209 W. High Street, St. Mary's, O.
1900. Shute, Albert Clement, 421 High Street, Pottstown, Pa.
1899. Siegfried, John P., 58 Center Street, Ashtabula, Ohio.
1896. Sigrist, Christopher W., Linden Heights, Columbus, Ohio.
1896. Sigrist, Philip H., E. High Street, New Philadelphia, Ohio.
1899. Silbernagel, Chas. Edward, 1033 N. High Street, Columbus, Ohio.
1901. Simonds, Edwin A., Carthage, N. Y.
1881. Simmons, Daniel, 1188 Dean Street, Brooklyn, N. Y.
1899. Simmons, Harry Benge, 18 Market Space, Chestertown, Md.
1902. Simmons, S. E., 82 W. Main Street, Norwalk, O.
1888. Simmons, Silas S., Susquehanna, Pa.
1881. Simon, Samuel H., 195 Garfield Place, Brooklyn, N. Y.
1899. Simpson, Edwin D., 320 W. 115th Street, New York, N. Y.
1896. Sinclair, Malcolm C., 124 Sheldon Street, Grand Rapids, Mich.
1854. SISSON, EDWARD R., New Bedford, Mass.

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1889. Skiles, Hugh P., 963 W. Monroe Street, Chicago, Ill.
1853. Skiles, Francis W., Suffolk, Va.
1899. Skinner, Scott W., Le Roy, N. Y.
1883. Slaught, James E., Warsaw, N. Y.
1891. Sleght, Bevier H. B., 31 Lincoln Park, Newark, N. J.
1900. Sloan, Malachi Wilson, 4830 Baltimore Avenue, W. Philadelphia, Pa.
1876. Slough, Frank J., Allentown, Pa.
1888. Slough, William C. J., Emaus, Pa.
1897. Small, Charles Kendall, Oakland, Cal.
1900. Small, Standley G., 152 Taggart Street, Allegheny, Pa.
1894. Smedley, Charles Davis, Wayne, Pa.
1899. Smilie, Nathan, 1524 Chestnut Street, Philadelphia, Pa.
1896. Smith, Charles C., Bedford, Mich.
1873. Smith, Chester, Portland, Mich.
1896. Smith, Dean T., 712 E. Washington Street, Ann Arbor, Mich.
1896. Smith, Dudley, 208 First Street, San Francisco, Cal.
1899. Smith, Francis A., 18 S. 4th Street, Zanesville, Ohio.
1891. Smith, George R., Dover, N. H.
1901. Smith, George Thomas, 5504 State Street, Chicago, Ill.
1882. Smith, Julia Holmes, Reliance Building, Chicago, Ill.
1887. Smith, Melvin D., 47 Ridge Street, Glens Falls, N. Y.
1885. Smith, Norman Pitt, 255 W. Court Street, Paris, Ill.
1893. Smith, Orrin L., 4841 Madison Avenue, Chicago, Ill.
1869. Smith, St. Clair, 25 W. 50th Street, New York, N. Y.
1860. Smith, T. Franklin, 264 Lenox Avenue, New York, N. Y.
1901. Smith, Milton S., La Porte, Ind.
1901. Smith, Sidney E., 77 Arlington Avenue, Brooklyn, N. Y.
1889. Smith, Wilson A., 11014 Walker Avenue, Morgan Park, Ill.
1894. Smythe, Samuel Scales, cor. California and 17th Streets, Denver, Col.
1891. Snader, Edward R., 140 N. 20th Street, Philadelphia, Pa.
1901. Snell, William M., Rochester, N. Y.
1900. Snyder, Elwood S., 425 North Queen Street, Lancaster, Pa.
1898. Snyder, Susan McGlaughlin, 121 S. 7th Street, Council Bluffs, Iowa.
1897. Sommer, Henry Otto, 1227 O Street, N. W., Washington, D. C.
1891. Sooy, Walter C., 1921 Pacific Avenue, Atlantic City, N. J.
1897. Southall, Edward W., Geneseo, N. Y.
1902. Souther, Robert F., 1122 Commonwealth Avenue., Boston, Mass.
1887. Southgate, Robert W., 2 Commonwealth Avenue, Boston, Mass.
1871. Southwick, Augustus B., 107 W. Liberty Street, Rome, N. Y.
1888. Southwick, George R., 31 Massachusetts Avenue, Boston, Mass.
1899. Spalding Harry O., 50 Seavern Avenue, Jamaica Plain, Boston, Mass
1869. Spalding, Henry E., 519 Beacon Street, Boston, Mass.
1895. Spalding, Julia H., 39 N. Main Street, Cortland, N. Y.
1892. Spalding, Samuel H., Hingham, Mass.
1859. Sparhawk, George, E. E., 150 Bank Street, Burlington, Vt.
1899. Spencer, Annie Whitney, 25 Batavia Avenue, Batavia, Ill.
1895. Spencer, George Frederick Allen, 40 Church Street, Ware, Mass.
1901. Spencer, Hazleton, 31 Commercial Street, Sherbrooke, Quebec, Can.
1891. Spencer, William, 1820 Chestnut Street, Philadelphia, Pa.
1897. Spencer, William Francis, Geneseo, Ill.

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1875. SPINNEY, ANDREW B., Reed City, Mich.
1892. Spranger, Michael J., 23 Adams Avenue, E., Detroit, Mich.
1882. Spreng, Theodore F. H., Iowa Building, Sioux City, Iowa.
1897. Stambach, Ida V., 1509 State Street, Santa Barbara, Cal.
1899. Starcke, Andrew H., 619 Kansas Avenue, Kansas City, Kan.
1891. Stark, Clinton E., Norwich, Conn.
1892. Stauffer, Alvin Packer, Hagerstown, Md.
1897. Stearns, George Raynolds, 207 Linwood Avenue, Buffalo, N. Y.
1896. Stearns, John S., 1425 Rhode Island Ave., N. W., Washington, D. C.
1891. Stearns, Solomon S., 1425 Rhode Island Ave., N. W., Washington, D. C.
1892. Stearns, William M., 34 Washington Street, Chicago, Ill.
1893. Stem, Henry L., Union City, Pa.
1899. Stenhouse-Goodrich, A. Amelia, 7142 Emerald Ave., Englewood, Ill.
1902. Stepfield, Alexander E., Doylestown, O.
1902. Stephens, Chas. N., 1899 Milwaukee Avenue, Chicago, Ill.
1889. Stephens, Aaron M., 431 Fourth Street, Red Wing, Minn.
1892. Stephens, James Arthur, 230 Euclid Avenue, Cleveland, O.
1898. Stephenson, Benjamin Swift, 49 Kirk Street, Lowell, Mass.
1901. Stevens, Juoquine M., Traverse City, Mich.
1896. Stevens, Rollin H., 6 Adams Avenue, W., Detroit, Mich.
1902. Stewart, Frank C., Indianapolis, Ind.
1897. Stewart, George Taylor, Rutland, Broadway and 57th Street, New York.
1901. Stewart, George W., 1728 Chestnut Street, Philadelphia, Pa.
1896. Stewart, Lincoln A., Brooksville, Me.
1900. Stewart, Ralph Alexander, Flower Hospital, Avenue A and 63d Street, New York, N. Y.
1888. Stewart, Thos. M., 704 Elm Street, Cincinnati, Ohio.
1899. Stewart, William A., Lenox, Mass.
1902. Stewart, Wm. R., 129 E. Ohio Street, Indianapolis, Ind.
1895. Stiles, Charles Wallace, 45 Beacon Street, Allston, Boston, Mass.
1890. Stiles, Frederick P., Sparta, Wis.
1895. Stiles, Hunter Bell, Grand Avenue, Gainesville, Tex.
1899. Stirk, James C., 4700 Chester Avenue, Philadelphia, Pa.
1900. Stitzel, Jonas Wakefield, Hollidayburg, Pa.
1879. Stone Martha M., 914 Prospect Street, Cleveland, O.
1887. Stone, Waldo H., 133 Orms Street, Providence, R. I.
1902. Storer, John, 1106-92 State Street, Chicago, Ill.
1895. Storer, John Hudson, 30 Edgecombe Avenue, New York, N. Y.
1902. Stough, Charles Francis, 122 E. Kiowa, Colorado Springs, Col.
1882. Stout, Henry R., Jacksonville, Fla.
1892. Stratton, Wallace C., 2255 Mission Street, San Francisco, Cal.
1899. Straughn, Clinton C., Matawan, N. J.
1891. Strawbridge, Frank A., Sigourney, Ia.
1901. Street, Richard H., 83 E. 20th Street, Chicago, Ill.
1902. Streeter, George Dallas, 216 N. Fifth St., Waco, Tex.
1869. STREETER, JOHN W., 2001 Prairie Avenue, Chicago, Ill.
1871. STREETS, JACOB G., Bridgeton, N. J.
1889. Strickler, David A., 705 Fourteenth Street, Denver, Col.

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1880. Strong, Thomas M., 176 Huntington Avenue, Boston, Mass.
1883. Stumpf, Daniel B., 693 Ellicott Street, Buffalo, N. Y.
1890. Sturtevant, Myron C., Morris, Ill.
1892. Styles, Elmer L., New Britain, Conn.
1891. Suffa, George A., 220 Clarendon Street, Boston, Mass.
1902. Suganuma, Mary A., Nagasaki, Japan.
1897. Sumner, Charles Oliver, 4 Park Street, Norwood, N. Y.
1881. Sumner, Charles R., 33 S. Clinton Street, Rochester, N. Y.
1887. Sutherland, John Preston, 295 Commonwealth Avenue, Boston, Mass.
1890. Suttle, Henry J., Viroqua, Wis.
1880. Swain, Mary L., 178 Huntington Avenue, Boston, Mass.
1895. Swan, Charles J., 34 Washington Street, Chicago, Ill.
1896. Swartwout, Frank A., 810 Eleventh Street, N. W., Washington, D. C.
1879. Swartz, J. Ross, 236 N. Third Street, Harrisburg, Pa.
1899. Sweet, Clara M., 2 Maple Street, Springfield, Mass.
1898. Sweet, E. C., 613 W. Monroe Street, Chicago, Ill.
1887. Swett, Emily F., Medina, N. Y.
1897. Swift, Arthur Wesley, 501 State Street, Belvidere, Ill.
1901. Swift, Edward P., 170 W. 88th Street, New York, N. Y.
1900. Sword, George P., Huntington, N. Y.
1891. Swormstedt, Lyman B., 1455 Fourteenth St., N. W., Washington, D. C.
1895. Sylvester, Stephen Alden, Beacon Street, Newton Centre, Mass.

1900. Taber, George A., 105 West Grace Street, Richmond, Va.
1888. Talbot, George H., Newtonville, Mass.
1890. Talbot, Winthrop Tisdale, Holderness, N. H.
1899. Talmage, Samuel, 22 Schermerhorn Street, Brooklyn, N. Y.
1897. Taylor, Alfred H., 485 H Street, S. W., Washington, D. C.
1898. Taylor, Edwin A., 34 Washington Street, Chicago, Ill.
1875. Taylor, Esther W., 36 Stedman Street, Boston, Mass.
1882. Taylor, Theodore H., Evansville, Ind.
1902. Taylor, Wm. Gardiner, 216 Locust Street, Columbia, Pa.
1901. Teal, Frederick F., Norfolk, Neb.
1892. Teets, Charles E., 56 W. 39th Street, New York, N. Y.
1894. Tennant, Chauncey E., 1155 Vine Street, Denver, Col.
1875. Terry, Marshall O., 196 Genesee Street, Utica, N. Y.
1901. Thatcher, William F., 411 Lintz Building, Dallas, Texas.
1902. Thego, Wm. Edgar, 1463 Cedar Avenue, Cleveland, Ohio.
1899. Theilmann, Emil, Fulton, Mo.
1899. Thomas, Arthur E., 3200 Indiana Avenue, Chicago, Ill.
1890. Thomas, Charles H., 427 Broadway, Cambridge, Mass.
1875. Thomas, Charles M., 1623 Arch Street, Philadelphia, Pa.
1900. Thomas, John Wix, Phœnix, Ariz.
1898. Thomasson, John Clay, 214 Main Street, Georgetown, Ky.
1887. Thome, Arthur G., 133 Lincoln Avenue, Chicago, Ill.
1888. Thompson, Charles S. W., Helena, Mont.
1887. Thompson, James Henry, 515 Penn Avenue, Pittsburg, Pa.
1890. Thompson, Jay J., 707 Marshall Field Building, Chicago, Ill.
1867. Thompson, John H., 36 E. 30th Street, New York, N. Y.

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1887. Thompson, Landreth W., 1701 Green Street, Philadelphia, Pa.
1891. Thompson, Mark M., 805 Monroe Street, Chicago, Ill.
1867. THOMPSON, VIRGIL, 32 W. 21st Street, New York, N. Y.
1891. Thompson, Will Sylvester, 173 State Street, Augusta, Me.
1902. Tilton, Nellie Morris, 15 Bartlett Street, Brockton, Mass.
1900. Tindall, Percy A., Homœepathic Hospital, Washington, D. C.
1887. Tobey, Walter Henry, 173 Newbury Street, Boston, Mass.
1897. Tomlin, Richard Elmer, 2057 N. 8th Street, Philadelphia, Pa.
1885. Tompkins, Albert H., 20 Seavern's Ave., Jamaica Plain, Boston, Mass.
1879. Tooker, Robert N., 263 Dearborn Avenue, Chicago, Ill.
1891. Townsend, Irving, 67 W. 46th Street, New York, N. Y.
1902. Trutt, J. Frank, 295 Main Street, Biddeford, Me.
1890. Treat, Charles R., Jr., Sharon, Wis.
1899. Trew, Bartus, 315 N. Paca Street, Baltimore, Md.
1896. Triem, Peter E., cor. Main and Madison Streets, Manchester, Ia.
1888. Trotter, Richard R., 189 Warburton Avenue, Yonkers, N. Y.
1888. Tucker, Genevieve, Pueblo, Col.
1892. Tuller, John J., 1931 Chestnut Street, Philadelphia, Pa.
1899. Tupper, John Darrow, Westport, Mass.
1894. Turbin, Louis M., 103 Randolph Street, Chicago, Ill.
1892. Turner, Maurice W., 127 Harvard Street, Brookline, Mass.
1902. Turrill, Geo. Edward, 176 Euclid Avenue, Cleveland, Ohio.
1896. Tuthill, Frank S., Concord, Mich.
1891. Tuttle, Edward G., 61 W. 51st Street, New York, N. Y.
1895. Tuttle, Walter, Court Street, Exeter, N. H.
1881. Tytler, George E., 113 W. 126th Street, New York, N. Y.

1881. Uebelacker, Armin E., 109 South Street, Morristown, N. J.
1891. Ullrey, Arthur O., Niles, Mich.
1892. Upham, Ella Prentiss, Asbury Park, N. J.

1889. Van Baun, William W., 1402 Spruce Street, Philadelphia, Pa.
1899. Van Delinder, Effie M., 556 Public Avenue, Beloit, Wis.
1889. Van den Burg, William H., 32 W. 49th Street, New York, N. Y.
1895. Vander Burgh, David W., 320 Rock Street, Fall River, Mass.
1899. Van Derveer, George W., Garden Street, Mt. Holly, N. J.
1900. Van Deursen, George Livesay, 17 Kirk Street, Lowell, Mass.
1891. Van Deusen, Edwin H., 2105 Tioga Street, Philadelphia, Pa.
1899. Van Gunten, Fred W., 1432 Diamond Street, Philadelphia, Pa.
1894. Van Lennep, Gustave Adolphe, 1615 Chestnut Street, Philadelphia, Pa.
1886. Van Lennep, William B., 1421 Spruce Street, Philadelphia, Pa.
1895. Van Loon, Arthur Burton, 50 Eagle Street, Albany, N. Y.
1873. VAN NORMAN, EDGAR V., 545 South Broadway, Los Angeles, Cal.
1870. VAN NORMAN, HORACE B., 289 Pearl Street, Cleveland, Ohio.
1901. Van Schoonhoven, Cornelius S., 1060 Lafayette Avenue, Brooklyn, N. Y.
1897. Van Scoyoc, Lloyd G., 1103 Main Street, Kansas City, Mo.
1876. VAN VLECK, PETER H., Sturgis, Mich.
1902. Varner, Anna Devinn, 616 Wood Street, Wilkinsburg, Pa.
1899. Varney, Edith Charles, 132 Broad Street, Lynn, Mass.
1896. Vehslage, Samuel H., 117 W. 43d Street, New York, N. Y.

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1891. Ver Nooy, Charles, 146 W. 64th Street, New York, N. Y.
1889. Vidal, James W., Fargo, N. Dak.
1877. VILAS, CHARLES H., 2811 Cottage Grove Avenue, Chicago, Ill.
1902. Vinyard, Guy Stewart, 1517 Welton Street, Denver, Colo.
1881. Vishno, Charles, 361 Orange Street, New Haven, Conn.
1895. Von der Luhe, Amelia D. F., 801 Driggs Avenue, Brooklyn, N. Y.
1900. Vreeland, Frank Dinwiddie, 316 Broadway, Paterson, N. J.

1900. Wage, Arnold Edwin, Granite Block, Albion, N. Y.
1897. Wage, John F., 414 Seneca Street, Buffalo, N. Y.
1893. Wagner, Philippina, Carson City, Nev.
1895. Wait, Oliver Babcock, 1230 S. 57th Street, Philadelphia, Pa.
1874. WAIT, PHOEBE J. B., 412 9th Avenue, New York, N. Y.
1897. Waite, Kent B., 610 The Rose Bldg., Cleveland, Ohio.
1901. Wakeley, William A., 420 So. Main Street, Orange, N. J.
1902. Walker, Hannah Ellen, 24 Shenango St., Sharon, Pa.
1902. Waldo, Elmer E., 1052 Broadway, Hannibal, Mo.
1888. Walker, James M., 1257 Broadway, Denver, Col.
1902. Wallace, C. R., Struthers, Ohio.
1902. Wallace, Homer Dawson, 214 Laycock Street, Allegheny, Pa.
1899. Walls, Charles Bruce, 134 So. Kedzie Avenue, Chicago, Ill.
1893. Walter, Robert, Walter's Park, Pa.
1872. WALTER, ZIBA D., 107 W. Seventh Street, Pueblo, Col.
1874. WALTON, CHARLES E., N. W. cor. 7th and John Streets, Cincinnati, Ohio.
1902. Waltz, Alvin L., 526 Prospect Street, Cleveland, Ohio.
1883. Wanstall, Alfred, 921 Cathedral Street, Baltimore, Md.
1899. Ward, Charles Austin, 33 Court Street, Binghamton, N. Y.
1889. Ward, Florence N., "The Wenban," 606 Sutter St., San Francisco, Cal.
1901. Ward, Henry A., Richfield Springs, N. Y.
1883. Ward, James W., "The Wenban," 606 Sutter St., San Francisco, Cal.
1891. Ward, John McE., 1915 W. Susquehanna Avenue, Philadelphia, Pa.
1891. Ware, Horace B., Scranton, Pa.
1898. Waring, Guernsey P., 504 Stewart Bldg., Chicago, Ill.
1898. Warner, Alton G., 19 Schermerhorn Street, Brooklyn, N. Y.
1873. WARREN, H. ANNA, 817 Bond Street, Dennison, Texas.
1872. WARREN, JOHN K., 68 Pleasant Street, Worcester, Mass.
1900. Wasgatt, Rowland John, Rockland, Me.
1892. Washburn, Julia, 294 N. Broadway, Lexington, Ky.
1873. WATERS, MOSES H., 126 N. Seventh Street, Terre Haute, Ind.
1901. Watson, Carl, 208 So. Main Street, Findlay, Ohio.
1854. WATSON, WILLIAM H., 270 Genesee Street, Utica, N. Y.
1901. Watters, Wm. Hy., 80 East Concord Street, Boston, Mass.
1901. Watts, Edith Gertrude, Hicks Building, San Antonio, Texas.
1891. Watts, Pliny R., 1010 Eighth Street, Sacramento, Cal.
1893. Watts, William, 339 Huron Street, Toledo, Ohio.
1899. Way, Frank E., Wahoo, Neb.
1894. Waylan, Julia Gould, 1832 Tioga Street, Philadelphia, Pa.
1894. Wayland, Charles A., Porter Building, San Jose, Cal.
1882. Weave, Chandler, Fox Chase P. O., Philadelphia, Pa.
1899. Weaver, Harry Sands, 1621 Chestnut Street, Philadelphia, Pa.

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1900. Weaver, Willis P., 320 Radcliffe Street, Bristol, Pa.
1901. Webb, William B., Beaver Dam, Wis.
1900. Webster, Frank, 700 Reibold Building, Dayton, Ohio.
1881. Webster, Frank P., 316 Freemason Street, Norfolk, Va.
1899. Webster, George C., 305 W. 7th Street, Chester, Pa.
1893. Webster, Samuel C., 99 High Street, Westerly, R. I.
1902. Welch, Charles Edgar, 12 West Columbus, Nelsonville, Ohio.
1888. Welch, George Oakes, Fergus Falls, Minn.
1899. Wedelstaedt, von, George Sparr, Deadwood, S. D.
1891. Weirick, Clement A., 100 State Street, Chicago, Ill.
1902. Welliver, James Everson, 111 N. Jefferson, Dayton, Ohio.
1902. Wells, Levy C., 719 Wheeling Avenue, Cambridge, O.
1899. Wells, David Washburn, "The Westminster," Copley Square, Boston, Mass.
1896. Wells, George S., Sistersville, W. Va.
1900. Wentworth, Caroline Young, 57 Lincoln Street, Newton Highlands, Mass.
1897. Wessel, Peter H., 517 Fifteenth Street, Moline, Ill.
1859. Wesselhoeft, Conrad, 661 Boylston Street, Boston, Mass.
1867. Wesselhoeft, Walter, 26 Garden Street, Cambridge, Mass.
1894. Wesselhoeft, William Fessenden, 851 Boylston Street, Boston, Mass.
1859. Wesselhoeft, William P., 176 Commonwealth Avenue, Boston, Mass.
1858. West, Edwin, No. 6 North Walnut Street, East Orange, N. J.
1901. West, Isaac C., 350 Elm Street, Dallas, Texas.
1901. Westfall, Floyd Edward, Homœopathic Hospital, Ann Arbor, Mich.
1899. Westney, Alfred W., 1302 Pacific Avenue, Atlantic City, N. J.
1901. Weston, Isabel G., Washington Street, Wellesley, Mass.
1899. Westover, Henry W., 7th and Edward Streets, St. Joseph, Mo.
1866. Wetmore, John McE., 43 W. 54th Street, New York, N. Y.
1900. Whaley, C. Bryant, 452 W. Broad Street, Savannah, Ga.
1898. Wheeler, Byron A., 1441 Stout Street, Denver, Col.
1898. Wherry, Curtis A., Ogden, Utah.
1882. Whipple, Alfred A., 637 Main Street, Quincy, Ill.
1899. Whitaker, Eugene E., Newport, Vt.
1902. Whitaker, Harry O., South Charleston, O.
1901. White, Benjamin R., Honeoye Falls, N. Y.
1897. White, A. Grace, 87 Main Street, Bradford, Pa.
1902. White, Florence R. Smith, Cardington, O.
1901. White, John C., Port Chester, N. Y.
1893. White, John T., 28 State Street, Salt Lake City, Utah.
1887. White, Roland T., 914 Western Avenue, Allegheny, Pa.
1893. White, William Seymour, 900 Marshall Field Building, Chicago, Ill.
1902. Whitehead, J. H., 43 Church Street, Bowling Green, O.
1888. Whiting, Walter B., Malden, Mass.
1890. Whitman, Frank S., Elgin, Ill.
1888. Whitmarsh, Henry A., 62 Jackson Street, Providence, R. I.
1898. Whitmore, Frank Beach, Chester, Pa.
1896. Wiggers, Henry H., 529 Everett Street, Cincinnati, Ohio.
1902. Wiggins, C. C., Osage, Ia.

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1901. Wiggins, Theo. C., 12 Veronia Place, Brooklyn, N. Y.
1881. Wilberton, Lawrence G., Winona, Minn.
1891. Wilbur, Bertrand K., The Indian Training School, Sitka, Alaska.
1883. Wilcox, De Witt G., 597 Elmwood Avenue, Buffalo, N. Y.
1886. Wilcox, Sidney Freeman, 51 W. 52d Street, New York, N. Y.
1897. Wilder, Carlton V., 4 West 5th Street, Atlantic, Iowa.
1855. WILDER, LOUIS 45 V., 55 W. 33d Street, New York, N. Y.
1891. Wiley, Rebecca W., 160 Main Street, Laconia, N. H.
1899. Wilkins, David W., 5219 Washington Avenue, Chicago, Ill.
1886. Wilkins, George H., 59 Woodland Road, Auburndale, Mass.
1902. Wilkins, Geo. R., 568 W. Madison Avenue, Cleveland, O.
1902. Wilkinson, Chas. H., 423 Macon Avenue, Canon City, Col.
1900. Willard, Harry Stearns, 102 Washington Street, Paterson, N. J.
1867. WILLARD, LEWIS H., 236 Western Avenue, Allegheny, Pa.
1896. Willard, Mary A., 156 Warren Avenue, West, Detroit, Mich.
1901. Willcox, George W., Eaton Street, Hamilton, N. Y.
1895. Williams, Carl A., 24 Washington Street, New London, Conn.
1901. Williams, Clarence Mason, Alpena, Mich.
1900. Williams, Eli Cone, "The Homestead," Hot Springs, Va.
1893. Williams, Frank Fay, 6 Goodrich Street, Canton, N. Y.
1891. Williams, Franklin E., Haddonfield, N. J.
1898. Williams, Margaret Cowen, 2909 Portland Avenue, Louisville, Ky.
1876. *WILLIAMS, NANCY T., Winthrop Court, Augusta, Me.
1892. Williams, Perry C., Texarkana, Texas.
1876. WILLIAMSON, ALONZO P., Pillsbury Building, Minneapolis, Minn.
1900. Williamson, Bemsley, Friendship, N. Y.
1872. WILLIAMSON, MATTHEW S., 1311 Arch Street, Philadelphia, Pa.
1902. Wilson, Chas. A., 313 Houston Street, San Antonio, Tex.
1859. WILSON, GROVE H., Meriden, Conn.
1902. Wilson, John E., 23 E. Forty-fifth Street, New York, N. Y.
1876. WILSON, JOSEPH H., Bellefontaine, Ohio.
1873. WILSON, MATTHEW T., 1666 Fall Street, San Francisco, Cal.
1901. Wilson, William Henry, 3129 Rhodes Avenue, Chicago, Ill.
1865. WILSON, THOMAS P., 74 Forest Street, Detroit, Mich.
1901. Wilson, William, 121 Bates Street, Akron, Ohio.
1892. Winchell, Walter B., 137 Berkley Place, Brooklyn, N. Y.
1902. Winnard, Wellington Leroy, 422 Main, Warsaw, Ill.
1899. Winslow, Thomas Hartley, San Louis Obispo, Cal.
1901. Wintsch, Carl Herman, 271 Fairmount Avenue, Newark, N. J.
1896. Wise, Julius C., 14 W. 12th Street, Kansas City, Mo.
1895. Wisner, Jacob Ward, Hagerstown, Md.
1899. Wiswall, Edward H., Washington Street, Wellesley, Mass.
1886. Wolcott, Edwin H., 57 S. Union Street, Rochester, N. Y.
1902. Wollam, J. Frank, Jerry, O.
1901. Wood, Fred Webster, 3901 Cottage Grove Avenue, Chicago, Ill.
1886. Wood, James C., Rose Building, Cleveland, Ohio.
1895. Wood, Nelson Mervin, 72 High Street, Charlestown, Mass.
1860. WOOD, ORLANDO S., 521 N. Y. L. Building, Omaha, Neb.

*Deceased since last meeting.

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1898. Woodbury, Ernest I., 212 No. Fourth Street, Burlington, Iowa.
1870. WOODBURY, WILLIAM H., Washington and State Streets, Chicago, Ill.
1901. Woodman, Robert C., State Hom. Hospital, Middletown, N. Y.
1896. Woodruff, William L., Troy, Pinal Co., Ariz.
1870. WOODWARD, ALFRED W., 130 Ashland Avenue, Chicago, Ill.
1869. WOODWARD, ALVIN M., 128 W. 13th Street, New York, N. Y.
1891. Woodward, George D., 211 Broadway, Camden, N. J.
1899. Woodward, Herbert B., 3034 Michigan Avenue, Chicago, Ill.
1895. Worcester, Frank D., Keene, N. H.
1888. Worcester, George W., Newburyport, Mass.
1895. Worcester, John Fonerden, 405 Washington St., Dorchester, Mass.
1872. WORCESTER, SAMUEL, 597 Congress Street, Portland, Me.
1902. Worth, Sidney, 606 Sutter Street, San Francisco, Cal.
1891. Wright, George H., Forest Glen, Md.
1881. Wrisley, John A., Lakeport, N. H.
1902. Wurtz, Charles B., 2431 N. Fifth St., Philadelphia, Pa.
1881. Wyman, Edmond L., Manchester Centre, Vt.

1900. Yale, Arthur Wells, 1901 Park Avenue, Philadelphia, Pa.
1881. Yoder, Daniel, Catasauqua, Pa.
1902. Young, Albert D., Panama, N. Y.
1892. Young, E. Weldon, 1023 Columbia Street, Seattle, Wash.
1902. Young, Geo. Alexander, Nebraska Hospital for Insane, Hospital, Neb.
1902. Young, Jas. W., Bellefontaine, O.
1902. Young, Willis Brock, 2344 Park Avenue, St. Louis, Mo.
1886. Youngman, Maurice D., 1618 Pacific Avenue, Atlantic City, N. J.

1902. Zbinden, Christian, 431 Nebraska Avenue, Toledo, O.
1898. Ziegenfus, A. Frank, 1124 Wallace Street, Philadelphia, Pa.
1902. Zwetsch, John D., Main Street, Gowanda, N. Y.

CORRESPONDING MEMBERS

1873. Tommaso Cigliano, M.D., Naples, Italy.
1876. W. Albert Haupt, M.D., Chemnitz, Saxony, Germany.
1876. John W. Hayward, M.D., 61 Shrewsbury Road, Birkenhead, Cheshire, England.
1876. Arthur C. Clifton, M.D., 9 Park Parade, Northampton, England.
1876. Thomas Skinner, M.D., 6 York Place, London, W., England.
1879. Alfred C. Pope, M.D., Monkton, Ramsgate, England.
1882. A. Claude, M.D., 43 Rue de Caumartin, Paris, France.
1885. Edward Blake, M.D., 65 Seymour Street, Hyde Park, W., England.
1889. Mohendra Lal Sircar, M. D., Calcutta, India.
1889. B. N. Banerjee, M.D., 34½ Beadon Street, Calcutta, India.
1891. Alexander Villiers, M.D., Dresden, Saxony, Germany.

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1891. D. Dyce Brown, M.D., 29 Seymour Street, Portman Square, London, W., England.
1891. Leopold Salzer, M.D., 6 Loudon Street, Calcutta, India.
1892. Frederick Delosea, M.D., Frankfort, Germany.
1892. August Grunewald, M.D., Frankfort, Germany.
1893. Alfred E. Hawkes, M.D., Liverpool, England.
1893. J. Cavendish Molson, M.D., 10 Walsingham Terrace, West Brighton, England.
1893. Oscar Hansen, M.D., Copenhagen, Denmark.
1893. P. C. Majundar, M.D., Calcutta, India.
1893. E. Vernon, M.D., Toronto, Ontario.
1895. U. C. Bagchi, M.D., Calcutta, India.
1895. C. S. Kali, M.D., L.M.S., Calcutta, India.
1897. Franz Edwein, M.D., Mainz, Germany.
1897. E. Mersch, M.D., Brussels, Belgium.
1897. Ernest Nyssers, M.D.
1902. E. Monterde, City of Mexico, Mexico.

HONORARY MEMBERS

1876. P. Jousset, M.D., Paris, France.
1876. R. E. Dudgeon, M.D., 22 Carlton Hill, London, W., England.
1892. Theodore Kafka, M.D., Karlsbad, Germany.

HONORARY ASSOCIATE MEMBERS

1879. Mrs. Elizabeth Thompson, New York, N. Y.
1883. Prof. N. B. Wood, Cleveland, Ohio.
1893. Madame Olga Bojanus, Samara, Russia.
1899. E. H. S. Bailey, Lawrence, Kan.

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LIST OF MEMBERS, CLASSIFIED BY STATES

Alabama.

BIRMINGHAM, Jefferson County.
Ballard, Asa N., M.D., 2020 Third Avenue.
HUNTSVILLE, Madison County.
Duffield, Alfred M., M.D., 307 Clinton Street.
MOBILE, Mobile County.
Lyon, George Gaines, M.D., Pollock Building.

Alaska.

PORT BARROW.
Marsh, Horatio Richmond, M.D.
SITKA.
Wilbur, Bertrand K., M.D.

Arizona.

PHOENIX, Maricopa County.
Hawley, Amasa, Sr., M.D.
Thomas, John Wix, M.D.
Woodruff, Wm. L., M.D., Second Ave. and Jefferson St.

Arkansas.

TROY, Pinal County.
Woodruff, Wm. L., M.D.
DEVALL BLUFF, Prairie County.
Mason, Stephen R., M.D.
EUREKA SPRINGS, Carroll County.
Regan, Milton R., M.D.
HOT SPRINGS, Garland County.
Dake, Charles, M.D.
Dake, Frank B., M.D.
Hallman, Victor H., M.D., 606½ Central Avenue.
Short, Zuber Nathaniel, M.D., 428 Central Avenue.
LITTLE ROCK, Pulaski County.
Green, Wm. E., M.D., 202 Center Street.

Australia.

MELBOURNE.
Ray, Wm. R., M.D., 26 Collins Street.

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CALIFORNIA

California.

ARLINGTON, Riverside County.
Robertson, Herbert M., M.D.

BAKERSFIELD, Kern County.
Congdon, Adeline B. Dake, M. D.
Dake, Adeline B. Crowley, M.D.

LONG BEACH.
Chaffee, John D., M.D.

LOS ANGELES, Los Angeles County.
Bishop, Herbert M., M.D., 2627 Hoover Street.
Buell, Edwin Charles, 449 So. Hill.
Campbell, Eugene, M.D., 315 South Broadway.
Dake, Benj. F., M.D.
Hawkes, Wm. J., M.D., 315 South Broadway.
Kirkpatrick, John C., M.D., 328 West Third Street.
Laird, F. F., M.D., 315 South Broadway.
Salisbury, Samuel Scott, M.D., Bradbury Building.
Van Norman, Edgar Vincent, M.D., 545 South Broadway.

MONROVIA, Los Angeles County.
Chamberlain, Myron H., M.D.

OAKLAND, Alameda County.
Chamberlain, Nelson Hoyt, M.D., Macdonough Building.
Fenton, Susan J., M.D., 672 Fourteenth Street.
Hill, Robert L., M.D., 564 Fourteenth Street.
Small, Charles Kendall, M.D.

ONTARIO, San Bernardino County.
Campbell, Robert Alexander, M.D.

PASADENA, Los Angeles County.
Beach, Eliza J., 50 Worcester Avenue.
Macomber, Henry Kirke, M.D.

PATTON, San Bernardino County.
Campbell, Merritt B., M.D.
Dolan, A. Stanley, M.D.
Richardson, George Henry, M.D.

RIVERSIDE, San Bernardino County.
Johnson, Robert B., M.D.

SACRAMENTO, Sacramento County.
Pinkham, Chas. B., M.D., 627 J Street.
Raver, Carl Frost, M.D., 806½ J Street.
Watts, Pliny R., M.D., 1010 Eighth Street.

SAN DIEGO, San Diego County.
Arndt, Hugo R., M.D., 951 60th Street.
Averall, Maria Brown, M.D., 3145 G Street.
Docking, Thomas, M.D., 164 Boston Avenue.
Lewis, J. Perry, M.D., 28th Street and National Avenue.

SAN FRANCISCO, San Francisco County.
Ballard, J. Stow, M.D., 610 Hyde Street.
Boericke, Wm., M.D., 1812 Washington Street.
Bryant, Edgar Reeve, M.D., 406 Sutter Street.

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Cameron, Ida B., M.D., 2653 Howard Street.
Canney, Frederick G., M.D., 606 Sutter Street.
Crawford, Alex. K., M.D., 406 Sutter Street.
Currier, Christopher B., M.D., 921½ Geary Street.
Goss, Alice Morgan, M.D., 606 Sutter Street.
Hoyle, Ethelbert Petrie, M.D., 506 Sutter Street.
Hurd, Laura B., M.D., 1301 Guerrero Street.
Martin, Eleanor Frances, M.D., 606 Sutter Street.
Martin, George Henry, M.D., 606 Sutter Street.
Minaker, Andrew J., 291 Valencia Street.
McConkey, Thomas Graham, 406 Sutter Street.
Palmer, George Henry, M.D., 606 Sutter Street.
Peterson, Alfred C., M.D., 135 Geary Street.
Smith, Dudley, M.D., 208 First Street.
Stratton, Wallace C., M.D., 2255 Mission Street.
Ward, Florence N., M.D., 606 Sutter Street.
Ward, James W., M.D., 606 Sutter Street.
Worth, Sidney, 606 Sutter Street.
Wilson, Matthew T., M.D., 166 Fell Street.

SAN JOSE, Santa Clara County.
Keith, William E., M.D., Porter Building.
Wayland, Charles A., M.D., Porter Building.

SAN LUIS OBISPO, San Luis Obispo County.
Winslow, Thomas Hartley, M.D.

SANTA ANA, Orange County.
Howe, Willella, M.D., 702 Bush Street.

SANTA BARBARA, Santa Barbara County.
Hatch, Philo L., M.D., 1901 San Pascual Street.
Stambach, Ida V., M. D., 1509 State Street.

SANTA CRUZ, Santa Cruz County.
Bennett, Ruth Parker, M.D., Lincoln and Pacific Avenues.

SANTA MONICA, Los Angeles County.
Hunt, John S., M.D.

Canada.

HAMILTON.
Bates, Frank D. W., M.D., 34 James Street, North.

MONTREAL.
Fisher, Arthur, M.D., Sherbrooke Street.
Griffith, Alex. Randall, M.D., 535 Wellington Street.
Patton, Arthur Douglas, M.D., 58 Crescent Street.
Patton, Charles James, M.D., 990 Sherbrooke Street.
Patton, Hugh Mathewson, M.D., 992 Sherbrooke Street.

SHERBROOKE, P. Q.
Spencer, Havelton, M.D., 31 Commercial Street.

TORONTO.
Anderson, Jeremiah N., M.D., 5 College Street.

WINNIPEG.
Clark, Charles F., M.D., 21 Princess Street.

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Chili, South America.

IQUIQUE.
Hoover, Willis C., M.D.

Colorado.

CANON CITY, Fremont County.
Howe, Warren D., M.D., 831 Main Street.
Wilkinson, Chas. H., 423 Macon Avenue.

COLORADO SPRINGS, El Paso County.
Beeler, Margaret Hoper, M.D., 1229 N. Tejon Street.
Faust, Frederick A., 21 E. Platt Avenue.
Lawrence, George W., M.D., 5 N. Tejon Street.
Sharetts, Upton A., M. D.
Stough, Charles Francis, 122 E. Kiowa.

DENVER, Arapahoe County.
Anderson, John Wylie, M.D., Steele Block.
Brace, Charles C., M.D., 1427 Stout Street.
Burnham, Norman G., M.D., 708 Fourteenth Street.
Burr, William Alton, M.D., 2010 Welton Street.
Cooke, Persifor Marsden, M.D., 1290 Race Street.
Cramer, Norman A.
Harris, John W., M.D., 613 Seventeenth Street.
Irvine, Joseph Clinton, M.D., Steele Block.
King, Edward H., M.D., 729 Sixteenth Street.
Kinley, Joseph B., M.D., 1401 Welton Street.
Mastin, James William, M.D., 25 18th Street.
Peck, Grant S., M. D., 1427 Stout Street.
Shannon, Samuel F., M.D., Jacobson Building.
Smyth, Samuel Scales, M.D., California and Seventeenth Streets.
Strickler, David A., M.D., 705 Fourteenth Street.
Tennant, Chauncey E., M.D., 1155 Vine Street.
Vinyard, Guy Stewart, 1517 Welton Street.
Walker, James M., M.D., 1257 Broadway.
Wheeler, Byron A., M.D., 1441 Stout Street.

EVANS, Weld County.
Horton, Daniel J., M.D.

FLORENCE, Fremont County.
Brooks, William F., M.D.

GOLDEN.
King, Walter Joel, M.D.

OPHIR, San Miguel County.
Compton, George William, M.D.

PUEBLO, Pueblo County.
Tucker, Genevieve, M.D.
Walter, Ziba D., M.D., 107 West Seventh Street.

Connecticut.

ANSONIA, New Haven, County.
Peck, Fred. Johnson, M.D., 44 Main Street.

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CONNECTICUT

BIRMINGHAM, New Haven County.
Phillips, Albert William, M.D.
BRIDGEPORT, Fairfield County.
Beebe, Wm. B., M.D., 197 Fairfield Avenue.
Gregory, Edward P., M.D., Lafayette, near State Street.
Payne, Clarence Niles, M.D., 385 State Street.
Sanford, Charles E., M.D.
DANBURY, Fairfield County.
Penfield, Sophia, M.D.
DEEP RIVER, Middlesex County.
Devitt, Frederick Wm., M.D.
GREENWICH, Fairfield County.
Piatti, Virgil C., M.D.
HARTFORD, Hartford County.
Angell, Augustus, M.D., 904 Main Street.
Case, Erastus E., M.D., 902 Main Street.
Cole, Harlan Page, M.D., 135 Sigourney Street.
Hooker, Edward Beecher, M.D., 721 Main Street.
Russegue, Henry E., M.D., 93 Farmington Avenue.
Shannon, Elmer Ellsworth, M. D.
IVORYTON, Middlesex County.
Shannon, Elmer Ellsworth., M.D.
MILFORD, New Haven County.
Putney, Willis S., M.D., Broad Street.
MYSTIC, New London County.
Barber, Oscar M., M.D.
NEW BRITAIN, Hartford County.
Peck, Fred. W., M.D., 42 Park Place.
Styles, Elmer L., M.D.
NEW CANAAN, Fairfield County.
Keeler, Charles B., M.D.
NEW HAVEN, New Haven County.
Cheney, Benjamin H., M.D., 45 Elm Street.
Sage, Henry P., M.D., 48 Howe Street.
Sage, William H., M.D., 48 Howe Street.
Vishno, Charles, M.D., 361 Orange Street.
NEW LONDON, New London County.
Allen, Albion H., M.D.
Williams, Carl A., M.D., 24 Washington Street.
NORFOLK, Litchfield County.
Sawtelle, Benjamin A., M.D.
NORWALK, Fairfield County.
Hitchcock, Dexter, M.D.
NORWICH, New London County.
Linnell, E. H., M.D.
Stark, Clinton E., M.D.
SOUTH NORWALK, Fairfield County.
Pardee, Emily V. D., M.D.
STAMFORD, Fairfield County.
Givens, Amos J., M.D., Stamford Hall.

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Pfeiffer, Harry Shriner, M.D.
Shirk, Samuel Martin, M.D., 35 Sumner Street.
Pulver, Frank Augustus, 88 Water Street.

UNIONVILLE, Hartford County.
Newton, John Burnell, M.D.

WILLIMANTIC, Windham County.
Colgrove, Charles H., M.D.

Delaware.

FREDERICA, Kent County.
Hoey, William F., M.D.
Hughes, Chas. Wilson, M.D., 1407 W. Eighth Street.

WILMINGTON, New Castle County.
Kittinger, Leonard, M.D., 411 Delaware Avenue.
Kittenger, Leonard Armour, M.D., 411 Delaware Avenue.
Negendank, Augustus, M.D., 1112 Washington Street.

District of Columbia.

WASHINGTON.
Babbitt, Zeno B., M.D., 12 Iowa Circle, N.W.
Baldwin, Aaron, M.D., 1205 Eleventh Street, N.W.
Branson, Joseph Holmes, M.D., 1231 New Jersey Avenue, N.W.
Brosuius, Mary Alice, M.D., 1101 K Street, N.W.
Burritt, Alice, M.D., 1129 Fourteenth Street, N.W.
Burritt, Martha Clark, M.D., 313 Fifth Street, S.E.
Choate, Rufus, M.D., 3267 O Street, N.W.
Corey, Waterman F., M.D., 1305 R Street, N.W.
Crichton, Macpherson, M.D., 922 Fourteenth Street, N.W.
Custis, George W. N., M.D., 112 East Capitol Street.
Custis, J. B. Gregg, M.D., 912 Fifteenth Street, N.W.
Custis, Marvin A., M.D., 634 East Capitol Street.
Davis, Charles A., M.D., 1010 Fifteenth Street, N.W.
Day, George F., M.D., 1405 Rhode Island Avenue.
Dennison, Ira Warren, M.D., 1312 L Street, N.W.
Emery, William Gorden, M.D., 1324 L Street, N.W.
Freer, James A., M.D., 1523 I Street, N.W.
Gardner, Franklin A., M.D., 1018 Fourteenth Street, N. W.
Gilbert, Charles B., M.D., 1444 Rhode Island Avenue.
Green, Julia M., M.D., 1738 N. Street, N.W.
Hawxhurst, Howard H., M.D., 1333 L Street, N.W.
Hislop, Margaret, M.D., 1021 Vermont Avenue, N. W.
Jenkins, Ralph, M.D., 1732 Massachusetts Avenue, N. W.
King, William R., M.D., 1422 K Street, N.W.
Kingsman, Richard, M.D., 711 East Capitol Street.
Krogsted, Henry, M.D., 1524 K Street, N.W.
Lee, George Hyde, M.D., 1620 Fifteenth Street, N.W.
Lothrop, Edwin S., M.D., 807 East Capitol Street.

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MacDonald, T. L., M.D., 1402 Massachusetts Avenue, N.W.
Moffit, Melvin M., M.D., 127 B Street, S.E.
O'Brien, Emile Young, M.D., 2504 19th Street, N.W.
Rauterberg, Arthur C., M.D., 510 Fifth Street, N.W.
Riggs, Daniel H., M.D., 1010 Eleventh Street, N.W.
Sharp, John R. Homœopathic Hospital.
Sharp, John R., Homœopathic Hospital.
Sherman, Nancy B., M.D., 700 Massachusetts Avenue, N.E.
Sommer, Henry Otto, M.D., 1227 O Street, N. W.
Stearns, John S., M.D., 1425 Rhode Island Avenue, N.W.
Stearns, Solomon S., M.D., 1425 Rhode Island Avenue, N.W.
Swartwout, Frank A., M.D., 810 Eleventh Street, N.W.
Swormstedt, Lyman B., M.D., 1455 Fourteenth Street, N.W.
Taylor, Alfred H., M.D., 485 H Street, S.W.
Tindall, Percy A., M.D., Homœopathic Hospital.

TAKOMA PARK, D. C.
Robinson, Samuel A., M.D.

Florida.

JACKSONVILLE, Duval County.
Johnson, Charles Ward, 35 E. Monroe.
Stout, Henry R., M.D.

MIAMI, Dade County.
Graham, Walter S., M.D.

TAMPA, Hillsboro County.
Bruce, Orpha D. B., M.D., 1302 Florida Avenue.

Georgia.

ATLANTA, Fulton County.
Hicks, Susan M., M.D., "The Grand."
Lawshé, John Z., M.D., 150 W. Peachtree Street.
Lukens, Merriken B., M.D., 159 Loyd Street.
Morse, Lucas Daniel, M.D., P. O. Box 584.
Orma, Francis Hodgson, M.D., 70 N. Forsythe Street.
Paine, Clarence M., M.D., 69 N. Forsythe Street.
Paine, Horace M., M.D., 67 Forsythe Street.

SAVANNAH, Chatham County.
Hanna, Lucy Shepard, M.D., 109 Bolton Street.
Whaley, Bryant C., M.D., 542 W. Broad Street.

Germany.

HAMBURG.
Pitcairn, Hugh, M.D.

STUTTGART.
Haehl, Richard, M.D.

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ILLINOIS

Illinois.

ATKINSON, Henry County.
Howlett, George Cleveland, M.D.
AURORA, Kane County.
Colwell, Charles Estabrook, M.D., 23 S. Lake Street.
Rice, Marvin S., M.D.
AUSTIN, Cook County.
Flint, Nellie C., M.D., 415 North Fifty-second Avenue.
McBurney, Benj. A., 200 South Park Avenue.
BATAVIA, Kane County.
Spencer, Annie Whitney, M.D.
BELLEVILLE, St. Clair County.
Loelkes, George, M.D., 202 South Jackson Street.
BELVIDERE, Boone County.
Swift, Arthur Wesley, M.D., 501 State Street.
BLOOMINGTON, McLean County.
Neiberger, William Emory, M.D., 402 W. Jackson Street.
CANTON, Fulton County.
Clemens, Frank L., M.D., 233 West Chestunt Street.
CASEY, Clark County.
Phelps, Chas. R., M.D., Jasper Avenue.
CENTRALIA, Marion County.
Dunn, Charles N., M.D., 300 Poplar Street.
CHICAGO, Cook County.
Adams, Charles, M.D., 100 State Street.
Allen, Henry C., M.D., 5142 Washington Avenue.
Aurand, Samuel Herbert, M.D., 720 Washington Boulevard.
Bailey, Edward Stillman, M.D., 3034 Michigan Avenue.
Barker, Clarence F., M.D., Ellis Avenue and Oakwood Boulevard.
Bell, James S., M.D., 2200 Congress Street.
Blackwood, Alexander L., M.D., 9151 Commercial Avenue.
Blouke, Milton Baker, M.D., 1222 West Washington Street.
Breyfogle, William L., M.D., 100 Washington Street.
Brown, Alice Barlow, M.D., 181 Dearborn Avenue.
Buffum, Joseph Howard, M.D., 34 Washington Street.
Chislett, Howard Roy, M.D., 3132 Prairie Avenue.
Clapp, Katherine B., M.D., 6222 Woodlawn Avenue.
Clark, Dwight Freeman, M.D., Cook County Hospital.
Cobb, Joseph P., M.D., 254 East Forty-seventh Street.
Collins, Clinton DeWitt, M.D., 92 State Street.
Conklin, Winfield Edwin, 2814 Groveland Avenue.
Costain, Thomas E., M.D., 100 State Street.
Cowperthwaite, Allen C., M.D., 31 Washington Street.
Day, Leonidas A. L., M.D., 103 State Street.
Delamater, Nicholas B., M.D., 31 Washington Street.
Duffield, Alice Virginia, M.D., 100 State Street.
Duncan, Francis, M.D., 100 State Street.
Ellis, Kate Walton, M.D., 4120 Lake Avenue.
Everett, Frederick, M.D., 420 Centre Street.
Fellows, C. Gurnee, M.D., 70 State Street.

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Fisher, Charles E., 103 State Street.
Forbes, William O., M.D., 3901 Cottage Grove Avenue.
Foster, Richard N., M.D., 553 Jackson Boulevard.
Fuller, Charles, M.D., 100 State Street.
Gatchell, Charles, M. D., 100 State Street.
George, Edgar J., M.D., 31 Washington Street.
Gilman, J. E., M.D., Hotel Metropole.
Gordon, Arthur H., M.D., 268 La Salle Avenue.
Graves Kate T., M.D., 5663 Washington Avenue.
Gross, James Eldridge, M.D., 222 Schiller Street.
Grosvenor, Lemuel C., M.D., 185 Lincoln Avenue.
Gwynne, Evan E., M.D., 556 Garfield Avenue.
Halbert, Homer V., M.D., 70 State Street.
Halphide, Aloin C., M.D., 3458 Wabash Avenue.
Hedges, Albert P., M.D., 754 E. Fullerton Avenue.
Hedges, Samuel Parker, M.D., 890 Evanston Avenue.
Hetherington, Judson Egbert, M.D., 1035 Warren Avenue.
Hill, George Mortimer, M.D., 4700 Grand Boulevard.
Hobart, Austin Walter, M.D., 118 Ashland Boulevard.
Hobson, Sarah Matilda, M.D., 5400 Madison Avenue.
Honberger, Frank Henry, M.D., 360 Oakwood Boulevard.
Hood, C. Todd, M.D., 992 W. Adams Street.
Jones, Mary H., M.D., Hyde Park.
Kahlke, Charles E., M.D., 3034 Michigan Avenue.
Karst, F. August, M.D., 636 Sedgwick Street.
King, J. B. S., M.D., 6713 Wentworth Avenue.
Kippax, John R., M.D., 4665 Indiana Avenue.
Leavitt, Sheldon, M.D., 148 Thirty-seventh Street.
Leipold, William Charles, M.D., 3702, Cottage Grove Avenue.
Low, Joseph Hooker, M.D., 2458 Indiana Avenue.
Lowenthal, Louis, M.D., 1405 W. 103d Street.
MacCracken, Mary E. Avery, M.D., 4327 Greenwood Avenue.
MacCracken, William P., M.D., 4327 Greenwood Avenue.
Martin, Chas. Velas, 2814 Groveland Avenue.
McBean, George Martin, M.D., 3326 Mt. Vernon Street.
McCauley, E. S. H.
McConnell, Carl P. 57 Washington Street.
McGibbon, Waldo P., 153 E. Fifty-third Street.
McKinney, Samuel P., M.D., 979 Warren Avenue.
Metcalf, Frank A., M.D., Forty-seventh Street and Kenwood Avenue.
Mitchell, Clifford, M.D., 70 State Street.
Newell, R. C., M.D., 70 State Street.
Payne, Hannah Jones, M.D.
Perkins, Ernest D., M.D., 1436 Monroe Street.
Pierce, Oscar F., M.D., 846 W. Twenty-second Street.
Pierson, Herman W., M.D., 100 State Street.
Pratt, E. H., M.D., 100 State Street.
Reininger, Edward E., M.D., 353 Oakley Boulevard.
Richard, George E., M.D., 44½ Bellevue Place.

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Schneider, S. Newton, M.D., 236 Dearborn Avenue.
Sawyer, E. W., M.D., 1416 Masonic Temple.
Shears, George F., M.D., 3130 Indiana Avenue.
Skiles, Hugh P., M.D., 936 W. Monroe Street.
Smith, George T., M.D., 5504 State Street.
Smith Julia Holmes, M.D., Reliance Building.
Smith, Orrin L., M.D., 4841 Madison Avenue.
Smith, Wilson A., M.D., 1104 Walker Avenue, Morgan Park.
Stearns, William, M.D., 34 Washington Street.
Stenhouse, A. Amelia Goodrich, M.D., 7142 Emerald Avenue (Englewood.)
Stephens, Chas. N., 1899 Milwaukee Avenue.
Storer, John, 1106-92 State Street.
Street, Richard H., M.D., 83 E. Twentieth Street.
Streeter, John W., M.D., 2001 Prairie Avenue.
Swan, Charles J., M.D., 34 Washington Street.
Sweet, E. C., M.D., 613 W. Monroe Street.
Taylor, Edwin A., M.D., 34 Washington Street.
Thomas, Arthur E., M.D., 100 State Street.
Thome, Arthur G., M.D., 133 Lincoln Avenue.
Thompson, Jay J., M.D., 707 Marshall Field Building.
Thompson, Mark M., M.D., 805 W. Monroe Street.
Tooker, Robert N., M.D., 263 Dearborn Avenue.
Turbin, Louis M., M.D., 103 Randolph Street.
Vilas, C. H., M.D., 2811 Cottage Grove Avenue.
Walls, Charles Bruce, M.D., 134 S. Kedzie Avenue.
Waring, Guernsey P., M.D., 504 Stewart Building.
Weirick, Clement A., M.D., 100 State Street.
White, William Seymour, M.D., 900 Marshall Field Building.
Wilkins, David W., M.D., 5219 Washington Avenue.
Wilson, Wm. Henry, M.D., 3129 Rhodes Avenue.
Wood, Fred Webster, M.D., 3901 Cottage Grove Avenue.
Woodbury, William H., M.D., Washington and State Streets.
Woodward, Alfred W., M.D., 130 Ashland Avenue.
Woodward, Herbert B., M.D., 3034 Michigan Avenue.

CLINTON, DeWitt County.
Bogardus, Charles S., M.D.
Porter, John Guernsey, M.D., 404 West Main.

CRETE, Will County.
Miessler, C. F., Otto, M.D.

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Blackman, Orville B., M.D.

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GENOA, De Kalb County.
Mordoff, Charles H., M.D.
HARVEY, Cook County.
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JACKSONVILLE, Morgan County.
Halsted, Milton A., M.D.
JOLIET, Will County.
Abell, E. J., M.D., 101 So. Center Street.
Beckwith, Henry M., M.D., 304 Banker Building.
Bergman, Nils, 400 Collins Street.
Davis, O. C., M.D., 323 Jeff Street.
Foote, William Kellogg, M.D., 306 Osgood Street.
Houston, Grant, M.D., 201 N. Chicago Street.
LA GRANGE, Cook County.
Llewellyn, Henry S., M.D., Fifth and Harris Avenues.
LA SALLE, La Salle County.
Coutant, George F., M.D.
LERNA, Coles County.
Leitch, Robert Newton, M.D.
LOCKPORT, Will County.
Courtney, John F., M.D., 916 Hamilton Street.
MARSEILLES, La Salle County.
Patton, William Mathewson, M.D.
MOLINE, Rock Island County.
Arp, August H., M.D.
Wessel, Peter H., M.D., 517 Fifteenth Street.
MORRIS, Grundy County.
Sturtevant, Myron C., M.D.
MOUNT PULASKI, Logan County.
Poppele, Charles F., M.D.
OAK PARK, Cook County.
Hendy, Clara A., M.D.
OTTAWA, La Salle County.
Bascom, Henry M., M.D., 728 Columbus Street.
PARIS, Edgar County.
Hunt, George H., M.D.
Smith, Norman Pitt, M.D., 255 W. Court Street.
PEORIA, Peoria County.
Kerr, Harlan T., M.D., 105 N. Perry Avenue.
PONTIAC, Livingstone County.
Long, Charles H., M.D., Sterry Block.

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ROCHELLE, Ogle County.
Gould, William W., M.D.
ROCKFORD, Winnebago County.
James, Katharine E., M.D., 123 N. Main Street.
Maas, Elizabeth C., M.D., 129 North Main Street.
ROCK ISLAND, Rock Island County.
Bradford, Eli, M.D., 632 Eighteenth Street.
SPRINGFIELD, Sangamon County.
Frazee, Calvin A., M.D., Illinois National Bank Bldg.
STERLING, Whiteside County.
Hill, Marion J., M.D., 507 Locust Avenue.
Winnard, Wellington Leroy, 422 Main.
WHEATON, Du Page County.
Owen, Charles S., M.D., 123 Main Street.
WOODSTOCK, McHenry County.
Primm, John W., M.D.

Indiana.

ANDERSON, Madison County.
Sears, Albert H., M.D., 139 West 9th Street.
BERNE, Adams County.
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ELKHART, Elkhart County.
Fisher, A. Leroy, M.D., 315 Pigeon Street.
EVANSVILLE, Vanderburg County.
Davis, Fielding L., M.D., 209 Locust Street.
Taylor, Theodore H., M.D.
FORT WAYNE, Allen County.
Bowen, George W., M.D., 232 East Washington Street.
GOSHEN, Elkhart County.
Kreider, Martin K., M.D.
GREENCASTLE, Putnam County.
Ayler, Amos E., M.D., 125 Washington Street.
INDIANAPOLIS, Marion County.
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Compton, J. Augustine, M.D., 115 E. Ohio Street.
George, Rebecca Rogers, M.D., W. Ohio and Meriden Streets.
George, William E., M.D., Ohio and Meriden Streets.
Runnels, O. S., M.D., 203 North Meriden Street.
Runnels, Sollis, M.D., 38 East Ohio Street.
Stewart, Frank C.
Stewart, Wm. R., 129 E. Ohio Street.
LA PORTE, Laporte County.
Martin, H. H., M.D., 710 Jefferson Street.
Smith, Milton S., M.D.
LEBANON, Boone County, Michigan City.
Coons, H. N., M.D., 404 East Pearl Street.
Martin, Francis V., M.D., 808 Franklin Street.

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MUNCIE, Delaware County .
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NASHVILLE, Brown County.
Harrell, N. H., M.D., 96 N. 10th Street.
NEW ALBANY, Floyd County.
Erni, G. Oscar, M.D., 809 East Spring Street.
NOBLESVILLE, Hamilton County.
Harrell, Samuel, M.D., North Tenth Street.
TERRE HAUTE, Vigo County.
Waters, Moses H., M.D., 126 North Seventh Street.
VALPARAISO, Porter County.
Ketchum, Frederick Grant, M.D., P. O. Building.

Indian Territory.

ARDMORE.
Peterman, Julius H., M.D.
OKMULGEE, Creek Nation.
Leslie, Samuel Brewster, M.D.

Iowa.

ALBIA, Monroe County.
King, Sylvester M., M.D.
ATLANTIC, Cass County.
Macomber, A. P., M.D.
Morse, Bertrand, M.D.
Wilder, Carleton V., M.D., 4 West Fourth Street.
BOONE, Boone County.
Martin, George Albert, M.D.
BURLINGTON, Des Moines County.
Woodbury, Ernest I., M.D., 212 North Fourth Street.
CEDAR FALLS, Blackhawk County.
Hansen, Andreas Schantz, M.D.
CEDAR RAPIDS, Linn County.
Cogswell, Charles H., 1011 Second Avenue.
CHARLES CITY.
Miner, Jas. B., M.D.
CLERMONT, Fayette County.
Becker, Frederick, M.D.
CLINTON, Clinton County.
Blunt, Arthur W., M.D., 323 Fifth Avenue.
COUNCIL BLUFFS, Pottawattamie County.
Hanchett, Alfred P., M.D., 120 Fourth Street.
Montgomery, Phineas J., M.D., 217 Fourth Street.
Snyder, Susan M., M.D., 121 South Seventh Street.
CRESTON, Union County.
Myers, Amos J., M.D.

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IOWA

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Hoefle, Henry C., M.D., 314 Brady Street.
DELPHOS, Ringgold County.
Prentis, Percy L., M.D.
DES MOINES, Polk County.
Aldrich, Stewart W., Grand Avenue.
Busenbark, Lucy M., M.D.
Drake, Joseph H., M.D., 826 West Fourth Street.
Eaton, Charles W., M.D., 420 Walnut Street.
Linn, A. M., M.D., 605 Walnut Street.
Royal, George, M.D., 505 Walnut Street.
DUBUQUE, Dubuque County.
Bray, Nicholas, M.D., 1140 Main Street.
Jackson, Edward R., M.D., 855 Locust Street.
FORT DODGE, Webster County.
Miner, Herbert Smith, M.D., 909 Central Avenue.
GRUNDY CENTRE, Grundy County.
Burns, Judson D., M.D.
INDEPENDENCE, Buchanan County.
Brooks, Caroline Frances, M.D.
IOWA CITY, Johnson County.
Gilchrist, James Grant, M.D., 215 College Street.
Hazard, Theodore Lincoln, M.D., 12 North Clinton Street.
KEOKUK, Lee County.
Bancroft, Walton, M.D.
Hoyt, Mary O., M.D., 26 North Fourth Street.
LAKE CITY, Calhoun County.
Humphrey, Howard M., M.D.
MADRID, Boone County.
Brown, E. C., M.D., Second and State Streets.
MAGNOLIA, Harrison County.
Cutler, Charles E., M.D.
MANCHESTER, Delaware County.
Dittmer, Ernest G., M.D.
Triem, Peter E., M.D., Main and Madison Streets.
MARION, Linn County.
Hindman, David R., M.D.
Moorhead, James, M.D., 743 Twelfth Street.
MASON CITY, Cerro Gordo County.
Cogswell, Chas. H., Jr., M. D.
MOUNT PLEASANT, Henry County.
Linn, Ellis Gregg, M.D.
OSAGE, Mitchell County.
Wiggins, C. C., M.D.
OSKALOOSA, Mahaska County.
Miller, Robert P., M.D., Evans Block.
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Remington, Fred. A., M.D.
Spreng, T. F. H., M.D., Iowa Building.
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Hayden, Arthur S., M.D.
WEBSTER CITY, Hamilton County.
Drake, Franklin Joseph, M.D.
WHITTIER, Linn County.
Ross, Alice Idella, M.D.

Italy.

FLORENCE.
Verdi, Tullio S., M.D., 11 Via delle Officine.

Japan.

NAGASAKI.
Suganuma, Mary A., M.D.

Kansas.

ATCHISON, Atchison County.
Johnson, George H. T., M.D.
CONCORDIA, Cloud County.
Raines, Taylor E., M.D., Sixth Street and Broadway.
GOESSEL, Marion County.
Richert, Peter, M.D.
KANSAS CITY, KAN.
Starcke, Andrew H., M.D., 609 Kansas Avenue.
KINGMAN, Kingman County.
Light, Jacob Wilbert, M.D.
LAWRENCE, Douglas County.
Gardner, Henry Seth, M.D., 823 Ken Street.
LINCOLN, Lincoln County.
Cole, Sarah A., M.D.
MARION, Marion County.
Barrows, George S., M.D.
PARSONS, Labette County.
Boardman, E. W., M.D., 115 Central Avenue.
PITTSBURG, Crawford County.
Canfield, Corresta, T., M.D., 513 N. Broadway.
SUMMERFIELD, Marshall County.
Matchett, John, M.D.
TOPEKA, Shawnee County.
Menninger, Charles Frederick, M.D., 727 Kansas Avenue.
WASHINGTON, Washington County.
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CARLISLE, Nicholas County.
Dills, Malcolm, M.D.
COVINGTON, Kenton County.
Reilly, William F., M.D., 1030 Madison Avenue.
FLEMINGSBURG, Fleming County.
Kehoe, Henry C., M.D.
FLEMINGTON.
Phillips, William O., M.D.
GEORGETOWN, Scott County.
Thomasson, John C., M.D., 214 Main Street.
LEXINGTON, Fayette County.
Johns, Emory B., M.D., 24 East Second Street.
Washburne Julia, M.D., 294 N. Broadway.
LOUISVILLE, Jefferson County.
Coon, George S., M.D., 617 Fourth Street.
Mann, Jessie E., M.D., Fonda Block.
Murphy, Sarah A., M.D., 727½ Eighth Street.
Williams, Margaret Cowen, M.D., 2909 Portland Avenue.
MIDWAY, Woodford County.
Kasselmann, Harry C., M.D.
NEWPORT, Campbell County.
Fischback, Frederick W., M.D.
OWENTON, Owen County.
Keppel, Frederick Dudley, M.D.
PADUCAH, McCracken County.
Enbanks, William Cicero, M.D., 306 Broadway.
RICHMOND, Madison County.
Holton, Charles Smoot, M.D., 316 Main Street.

Louisiana.

NEW ORLEANS, Orleans County.
Aiken, John Gale, M.D., 1102 St. Charles Avenue.
Mayer, Charles R., M.D., 1032 St. Charles Avenue.

Maine.

AUBURN, Androscoggin County.
Renwick, Wano J., M.D., 102 Goff Street.
AUGUSTA, Kennebec County.
Hill, W. Scott, M.D., 134 State Street.
Thompson, W. S., M.D., 173 State Street.
Williams, Nancy T., M.D., Winthrop Court.
BANGOR, Penobscot County.
Fellows, William Edwin, M.D., 134 Hammond Street.
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BELFAST, Waldo County.
Flanders, David P., M.D.
BIDDEFORD, York County.
Trutt, J. Frank, M.D., 295 Main Street.
BROOKSVILLE, Hancock County.
Stewart, Lincoln A., M.D.
CASTINE, Hancock County.
Cushman, Mary Floyd, M.D., Main Street.
GARDNER, Kennebec County.
Heath, Gertrude Emma, M.D., 164 Water Street.
PORTLAND, Cumberland County.
Shackford, Rufus, M.D.
Worcester, Samuel, M.D., 597 Congress Street.
ROCKLAND, Knox County.
Wasgatt, Rowland John, M.D.
SAGO, York County.
Graves, S. P., M.D.
SKOWHEGAN, Somerset County.
Johnson, Cora May, M.D.
SOLON, Somerset County.
Paul, C. Almon, M.D.
WATERBOROUGH, York County.
Emery, John Taylor Gilman, M.D., 27 Main Street.

Maryland.

BALTIMORE, Baltimore County.
Barnard, James S., M.D., 2734 North Charles Street.
Brewster, Cora B., M.D., 1027 Madison Avenue.
Brewster, Flora A., M.D., 1221 Madison Avenue.
Chandlee, Henry, M.D., 704 West North Avenue.
Cole, Edw. Z., M.D., 1516 Mt. Royal Avenue.
Comstock, William C., M.D., 407 North Charles Street.
Evans, John, M.D., 22 N. Carey Street.
Evans, Henry J., M.D., Fayette and Carey Streets.
Janney, O. Edward, M.D., 837 North Eutaw Street.
Miller, Irving, M.D., 1734 St. Paul Street.
Morgan William L., M.D., 202 West Franklin Street.
Panebaker, William Milton, M.D., 1103 Linden Avenue.
Parkhurst, Alice S., M.D., 1410 Park Avenue.
Peddicord, Harper, M.D., 801 N. Fulton Avenue.
Plumb, Amy E., M.D., 913 North Fulton Avenue.
Price, Eldridge C., M.D., 1012 Madison Avenue.
Rumsey, Charles Leslie, M.D., 812 Park Avenue.
Shearer, Thomas, M.D., 345 North Charles Street.
Shearer, Thomas L., M.D., 345 North Charles Street.
Shower, George Theodore, M.D., 421 Roland Avenue.
Trew, Bartus, M.D., 315 North Paca Street.
Wanstall, Alfred, M.D., 921 Cathedral Street.

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Garrison, Joseph Sherman, M.D.
FOREST GLEN, Montgomery County.
Wright, George H., M.D.
FREDERICK, Frederick County.
Burck, Lewis A., M.D., 17 East Second Street.
Goodell, Charles F., M.D., 19 East Patrick Street.
Hendrix, John Oliver, Castle Building.
HAGERSTOWN, Washington County.
Stauffer, Alvin P., M.D.
Wisner, Jacob Ward, M.D.
ROCKVILLE, Montgomery County.
Andrews, William R., M.D.

Massachusetts.

ADAMS, Berkshire County.
Bond, Aaron John, M.D., 1 Center Street.
ALLSTON, Suffolk County.
Stiles, Charles Wallace, M.D., 45 Beacon Street.
ANDOVER, Essex County.
Clarke, Henry L., M.D., 3 Punchard Avenue.
Sanborn, Emma M. E., M.D., 4 Morton Street.
Scott, Cyrus W., M.D., 90 Main Street.
ATHOL, Worcester County.
Forbes, Charles Holt, M.D., 429 School Street.
Larkeque, Garrett B. B., M.D., 345 Main Street.
AUBURNDALE, Middlesex County.
Clarke, Mortimer Hall, M.D., 221 Auburn Street.
Wilkins, Geo. H., 59 Woodland Road.
BOSTON, Suffolk County.
Allard, Frank E., M.D., 373 Commonwealth Avenue.
Angell, Henry C., M.D., 16 Beacon Street.
Appleton, Lucy, M.D., 711 Boyston Street.
Barnes, William Ellsworth, M.D., 432 Columbia Avenue.
Batchelder, Frederick P., M.D., 411 Massachusetts Avenue.
Bell, James B., M.D., 178 Commonwealth Avenue.
Bellows, Howard P., M.D., 220 Clarenden Street.
Bender, Prosper, M.D., Exeter Chambers.
Briggs, Joseph Emmons, M.D., 206 Huntington Avenue.
Burroughs, Amelia, M.D., 31 Massachusetts Avenue.
Cahill, Eliza B., M.D., Westminster, Copley Square.
Calderwood, Samuel Herbert, M.D., 221 Warren Street.
Chandler, Thomas Evans, M.D., 13 Sparhawk Street, Brighton.
Childs, Helen S., M.D., 454 Centre Street, Jamaica Plain.
Church, Adaline B., M.D., 102 Huntington Avenue.
Clapp, James Wilkinson, M.D., 10 Park Square.

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Colburn, Frederick Wilkinson, M.D., 35 Newbury Street.
Coon, Marion, M.D., Hotel "Ilkey."
Cross, Hiram B., M.D., 21 Seavern's Avenue, Jamaica Plain.
Cummings, M. Louisa, M.D., 178a Tremont Street.
Davis, Fred A., M.D., 80 Huntington Avenue.
Drake, Olin M., M.D., 70 Huntington Avenue.
Earl, George H., M.D., 153 Newbury Street.
Emerson, Nathaniel Waldo, M.D., 685 Boylston Street.
Flint, Almena J. Baker, M.D., 102 Huntington Avenue.
Fuller, Walter Tracy, M.D., Washington Street, Mt. Bowdoin.
Gary, Clara Emerette, M.D., 416 Marlborough Street.
Gooding, E. Jeannette, M.D., 223 W. Springfield Street.
Halsey, Frederick W., M.D., 272 Newberry Street.
Hill, Noble Hind, M.D., 35 Huntington Avenue.
Houghton, Neihard H., M.D., 867 Boylston Street.
Jackson, William L., M.D., 76 Dudley Street, Roxbury.
Kennedy, Alonzo L., M.D., 286 Newberry Street.
Krauss, James, M.D., 419 Boylston Street.
Krebs, Francis H., M.D., 42 Union Park.
Loring, Benjamin Tappan, M.D., Massachusetts Homœopathic Hospital, East Concord Street.
Mann, Martha Elizabeth, M.D., 2 Commonwealth Avenue.
Mann, William P., M.D., East Concord Street.
Miller, Lisbeth Dora, M.D., 12 Cordis Street.
Mosher, Mary E., M.D., 53 Blue Hill Avenue, Roxbury.
Packard, Horace, M.D., 470 Commonwealth Avenue.
Paul, Williard A., M.D., Standish Street, Dorchester.
Payne Frederick W., M.D., 100 Boylston Street.
Payne, James H., M.D., 344 Commonwealth Avenue.
Payne, John Howard, M.D., Pierce Building, Copley Square.
Pearson, Mary M., M.D., 361 Massachusetts Avenue.
Pease, Ella Gertrude, M.D., 214 Commonwealth Avenue.
Perkins, Nathaniel R., M.D., 1122 Adams Street, Dorchester.
Ransom, Eliza Taylor, 373 Commonwealth Avenue.
Rice, George Brackett, M.D., 220 Clarendon.
Richardson, Frank C., M.D., 685 Boylston Street.
Sanders, Orren B., M.D., 385 Commonwealth Avenue.
Sawyer, Willis Herbert, M.D., "The Peabody."
Sherman, James Turner, M.D., 29 Virginia Street.
Sherman, John H., M.D., 534 Broadway.
Smith, Conrad, M.D., 279 Dartmouth Street.
Souther, Robert F., 1122 Commonwealth Avenue.
Southgate, Robert W., M.D., 2 Commonwealth Avenue.
Southwick, George R., M.D., 31 Massachusetts Avenue.
Spalding, Harry O., M.D. 50 Seaverns Ave., Jamaica Plain.
Spalding, Henry E., M.D., 519 Beacon Street.
Strong, Thomas M., M.D., 176 Huntington Avenue.
Suffa, George A., M.D., 220 Clarendon Street.
Sutherland, John Preston, M.D., 295 Commonwealth Avenue.

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Swain, Mary L., M.D., 178 Huntington Avenue.
Taylor, Esther W., M.D., 36 Steelman Street.
Tobey, Walter Henry, M.D., 173 Newbury Street.
Tompkins, Albert H., M.D., 20 Seavern's Avenue, Jamaica Plain.
Watters, William Henry, M.D., 80 East Concord Street.
Wells, David Washburne, M.D., "The Westminster," Copley Square.
Wesselhoeft, Conrad, M.D., 661 Boylston Street.
Wesselhoeft, William Fessenden, M.D., 851 Boylston Street.
Wesselhoeft, William P., M.D., 176 Commonwealth Avenue.

BROCKTON, Plymouth County.
Brown, Daniel E., M.D., 95 Main Street.
Tilton, Nellie Morris, 15 Bartlett Street.

BROOKLINE, Norfolk County.
Jones, Everett, M.D., 1618 Beacon Street.
Moore, J. Herbert, M.D.
Percy, Frederick B., M.D.
Turner, Maurice W., M.D., 127 Harvard Street.

CAMBRIDGE, Middlesex County.
Chase, Herbert A., M.D., 950 Massachusetts Avenue.
Chase, Hiram L., M.D., 924 Massachusetts Avenue.
Diemer, Lena Hess, M.D., 1626 Massachusetts Avenue.
Rockwell, Jno. A., Jr., M.D., 26 Garden Street.
Thomas, Charles Holt, M.D., 427 Broadway.
Wesselhoeft, Walter, M.D., 26 Garden Street.

CHARLESTOWN, Suffolk County.
Allen, Edward Everett, M.D., 385 Main Street.
Wood, Nelson Mervin, M.D., 72 High Street.

CHELSEA, Suffolk County.
Rollins, Charlotte A., M.D.

DEDHAM, Norfolk County.
Babcock, Francis L., M.D., 15 Walnut Street.

DORCHESTER, Suffolk County.
Damon, Newcomb Lincoln, M.D., 405 Washington Street.
Emerson, Frederick Lincoln, M.D., 50 Hancock Street.
Fuller, Walter Tracy, M.D., 31 Harvard Street.
Hornby, Mary Stamper, M.D.
Worcester, John Fonerden, M.D., 405 Washington Street.

EAST WEYMOUTH, Norfolk County.
Chase, Joseph, Jr., M.D.

FALL RIVER, Bristol County.
Babcock, D. A., M.D.
Hill, Lucy Chaloner, M.D., 492 N. Main Street.
Van der Burgh, David W., M.D., 320 Rock Street.

FITCHBURG, Worcester County.
Bennett, William Henry, M.D.
Bingham, Russell, M.D., 62 Day Street.
Perkins, Archie Elmer, M.D., 82 Day Street.

FRAMINGHAM, Middlesex County.
Keith, Ellen L., M.D., Winter Street.

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GARDNER, Worcester County.
Colby, Edwin A., M.D.
GLOUCESTER, Essex County.
Conant, Thomas, M.D.
HAVERHILL, Essex County.
Hubbell, Adelbert M., 107 Winter Street.
Jewett, Howard Clifton, 75 Vine Street.
HINGHAM, Plymouth County.
Spalding, Samuel H., M.D.
KINGSTON, Plymouth County.
Barstow, Benjamin P., M.D.
LAWRENCE, Essex County.
Dunham, George Perry, M.D., 252 Broadway.
Earley, William C., M.D., 117 East Haverhill.
Scott, Chester W., M.D.
LEOMINSTER, Worcester County.
Latham, Carrie Augusta, M.D., 38 Central Street.
Miller, Edward Roscoe, M.D., 15 Merriam Street.
LEXINGTON, Middlesex County.
Piper, Fred Smith, M.D.
LOWELL, Middlesex County.
Holt, Edward B., M.D.
Leland, Clarence H., M.D., 202 Merrimac Street.
Martin, G. Forest, M.D., 17 Kirk Street.
Stephenson, Benjamin S., M.D., 49 Kirk Street.
Van Duersen, George Livesay, M.D., 17 Kirk Street.
LYNN, Essex County.
Haywood, George William, M.D., 45 Hanover Street.
Hopkins, William T., M.D., 65 Broad Street.
Varney, Edith Charles, M.D., 132 Broad Street.
MALDEN, Middlesex County.
Hodgdon, Frank A., M.D., 83 Salem Street.
Whiting, Walter B., M.D.
MARBLEHEAD, Essex County.
Devereaux, Jane S., M.D., 78 Pleasant Street.
MATTAPAN, Suffolk County.
Palmer, Anna Chipman, M.D., Houston Avenue.
MIDDLEBORO, Plymouth County.
Cummings, Charles Stearn, M.D., 40 Oak Street.
Fryer, Winsor F., M.D., 26 Oak Street.
MONSON, Hampden County.
Rand, John Prentice, M.D., 74 Main Street.
NANTUCKET, Nantucket County.
Coleman, Ellingwood B., M.D., Centre Street.
NEW BEDFORD, Bristol County.
Hunt, Charles R., M.D., 474 County Street.
Seip, Charles Lewis, M.D., 299 Union Street.
Shaw, John Cook, M.D., 23 S. Sixth Street.
Sisson, Edward R., M.D.

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NEWBURYPORT, Essex County.
Foss, David, M.D.
Johnson, Frederick Charles, M.D., 26 Market Street.
Worcester, George W., M.D.

NEWTON, Middlesex County.
Bothfeld, James F., M.D., 148 Church Street.
Reed, Clara D. W., M.D., 140 West Church Street.
Scales, Edward P., M.D.

NEWTON CENTRE, Middlesex County.
May, George Elisha, M.D., Institution Avenue and Beacon Street.
Sylvester, Stephen Alden, M.D., Beacon Street.

NEWTON HIGHLANDS, Middlesex County.
Eaton, Samuel Lewis, M.D.
Wentworth, Caroline Young, M.D., 57 Lincoln Street.

NEWTONVILLE, Middlesex County.
Talbot, George H., M.D.

NORTHAMPTON, Hampshire County.
Copeland, Elmer C., M.D., 70 Elm Street.
Darby, Edward A., M.D.
Darby, Margaret G., M.D.

ORANGE, Franklin County.
Monroe, John Eugene, M.D.

PITTSFIELD, Berkshire County.
Noyes, Henry A., M.D.

PLYMOUTH, Plymouth County.
Shaw, John Joseph, M.D., 14 Brewster Street.

SALEM, Essex County.
Gardner, Frank Augustine, M.D., 23 North Street.
Morse, Chas. W., M.D., 98 Washington Street, E.
Mudge, Catherine Gertrude, M.D., 309 Essex Street.
Percy, George Emory, M.D.

SOMERVILLE, Middlesex County.
Carvill, Alphonso H., M.D.
Newton, Frank Loomis, M.D., 147 Highland Avenue.
Peasley, Emma Janet, M.D.

SOUTHBRIDGE, Worcester County.
Edwards, Franklin W., M.D., 26 Hamilton Street.

SOUTH LINCOLN, Middlesex County.
Blodgett, Stephen H., M.D.

SPRINGFIELD, Hampden County.
Bennitt, Francis N., M.D., 120 Sumner Avenue.
Brown, Plumb, M.D., 503 State Street.
Carmichael, John H., M.D., 41 Maple Street.
Cushing, Alvin M., M.D., 137½ State Street
Parsons, Clarice Johnston, M.D., 177 State Street.
Rice, Harry Edwin, M.D., Exeter Chambers.
Roberts, Oscar Waldo, M.D., 24 Thompson Street.
Sweet, Clara Maria, M.D., 2 Maple Street.

STONEHAM, Middlesex County.
Jenney, Arthur Barker, M.D., 38 Franklin Street.

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Dwinell, Byron L., M.D.
Hayward, Joseph W., M.D.
WALTHAM, Middlesex County.
Emery, Winfred ewell, M.D., 808 Main Street.
WARE, Hampshire County.
Spencer, George Frederick Allen, M.D., 40 Church Street.
WAREHAM, Plymouth County.
Gleason, Charles Sherman, M.D.
WELLESLEY, Norfolk County.
Weston, Isabel G., M.D., Washington Street.
Wiswall, Edward H., M.D.
WESTBRO, Worcester County.
Adams, George Smith, M.D.
Buhrman, Ettie Ray, M.D.
Klopp, Henry Irwin, M.D.
WEST NEWTON, Middlesex County.
Paine, N. Emmons, M. D.
WESTPORT, Bristol County.
Tupper, John Darrow, M.D.
WEST ROXBURY, Suffolk County.
Howard, Alonzo Gale, M.D., 1977 Centre Street.
WOBURN, Middlesex County.
Chalmers, Robert, M.D., 47 Pleasant Street.
Packer, Henry E., M.D., 11 Pleasant Street.
WORCESTER, Worcester County.
Allen, Lamson M.D., 20 Elm Street.
Barton, J. Marcus, M.D.
Bray, Amanda C., M.D., 4 Wellington Street.
Crisand, Carl, M.D., 2 Charlotte Street.
Forbes, George F., M.D., 42 Williams Street.
Leib, Edwin Roy, M.D., 49 Pleasant Street.
Nichols, Charles L., M.D., 248 Main Street.
Rockwell, Alfred Elijah Perkins, M.D., 248 Main Street.
Warren, John K., M.D., 68 Pleasant Avenue.

Michigan.

ADRIAN, Lenawee County.
Lards, Charles H., M.D., 33 Butler Street.
ALLEGAN, Allegan County.
Osman, Elmer Douglas.
ALPENA, Alpena County.
Williams, Clarence M., M.D.
ANN ARBOR, Washtenaw County.
Copeland, Royal S., M.D., 407 N. Ingalls.
Dewey, Willis A., M.D.
Hinsdale, Wilbert B., M.D.
Kinyon, Claudius B., M.D.
Myers, Dean Wentworth, M.D., 345 S. Division Street.

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MICHIGAN

Smith, Dean T., M.D., 712 E. Washington Street.
Westfall, Floyd E., M.D., Homœopathic Hospital.

BAY CITY, Bay County.
Ball, Joseph Harris, M.D.
Edmunds, Charles W., Sixth and Adams Streets.
Nottingham, John C., M.D., 218 Fifth Avenue.

BEDFORD, Calhoun County.
Smith, Charles C., M.D.

BROOKLYN, Jackson County.
Jones, Leonidas M., M.D.

CARO, Tuscola County.
Chase, Sherman F.

CHARLOTTE, Eaton County.
Allen, Sarah J., M.D., 324 Lawrence Avenue.

CONCORD, Jackson County.
Tuthill, Frank S., M.D.

DETROIT, Wayne County.
Augustin, George William, 469 Third Avenue.
Babington, John, M.D., Miami Avenue.
Bailey, William M., M.D., 25 Miami Avenue.
Bowen, Emma K., M.D., 156 St. Aubirn Avenue.
Caron, George C., M.D., 30 Henry Street.
Cumrine, Charles G., M.D., 1444 Majestic Building.
Diehel, Wm. H., 505 Mack Street.
Graham, Alfred, 270 Woodward Avenue.
Griffin, Judson M., M.D., 106 Miami Avenue.
Hoff, Edward C., Grace Hospital.
Knight, Stephen H., M.D., 18 W. Willis Avenue.
LaSeure, Oscar, M.D., 406 Cass Avenue.
MacLachlan, Daniel A., M.D., 1301 Majestic Building.
Miller, Christopher C., M.D., 31 Winder Street.
Obetz, Henry L., M.D., 139 First Street.
Olin, Rollin C., M.D., 110 Henry Street, W.
Orleman, E. Louise, M.D., 32 Bagg Street.
Spranger, M. J., M.D., 23 Adams Avenue.
Stevens, Rollin B., 6 Adams Avenue, W.
Willard, Mary A., M.D., 156 Warren Avenue, W.
Wilson, Thomas P., M.D., 74 Forest Street, E.

DOWAGIAC, Cass County.
Herkimer, George R., M.D.

GALIEN, Berrien County.
Clark, Stanley A., M.D.

GRAND HAVEN, Ottawa County.
Reynolds, John N., M.D.

GRAND RAPIDS, Kent County.
Brigham, Homer C., M.D., 27 Morris Avenue.
Hoxie, Albertus T., M.D., Porter Block.
Norris, Maria, Whittelsey, M.D., Widdicomb Building.
Sinclair, Malcolm C., M.D., 124 Sheldon Street.

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HOLLY, Oakland County.
Bartholomew, Daniel D., M.D.
HOWELL, Livingston County.
Mills, Wesley, J., M.D.
IONIA, Ionia County.
Defendorf, John J., M.D.
IRVING, Barry County.
Hendershott, Lizzie A., M.D.
KALAMAZOO, Kalamazoo County.
Ayres, James N., M.D., 534 S. Burdick Street.
Balyeat, Edmund A., M.D., 122 W. Main Street.
Cornell, Albert B., M.D.
LANSING, Ingham County.
Jenkins, Charles G., M.D., 224 Washington Avenue.
Nottingham, David M. M.D.
MARINE CITY, St. Clair County.
Armsbury, Aaron B., M.D.
MASON.
Mann, George E., M.D.
MOUNT CLEMENS, Macomb County.
Lenfesty, John A., M.D., 8 S. Gratiot Avenue.
MUSKEGON, Muskegon County.
Marvin, La Ray, M.D., 221 Clay Avenue.
NILES, Berrien County.
Ullrey, Arthur O., M.D.
OWOSSO, Shiawassee County.
Crum, J. D., M.D., 314 N. Ball Street.
PETOSKEY, Emmet County.
Ramsdell, Oscar Luman, M.D.
PORTLAND, Ionia County.
Allen, George D., M.D.
Smith, Chester, M.D.
REED CITY, Osceola County.
Spinney, Andrew B., M.D.
SAGINAW, Saginaw County.
Cowell, Joseph H., M.D., 301 S. Warren Avenue.
SAULT STE. MARIE, Mich.
Husband, Francis H., M.D.
SPRING LAKE, Ottawa County.
Baker, Harley Nathan, M.D.
ST. JOHNS, Clinton County.
Dodge, John B., M.D.
STURGIS, St. Joseph County.
Van Vleck, Peter H., M.D.
TECUMSEH, Lenawee County.
Frost, William A., M.D.
THREE RIVERS, St. Joseph County.
Clark, Whitman E., M.D.
TRAVERSE CITY, Mich.
Stevens, Juoquine M., M.D.

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Cornue, P. W., M.D., 9 Washington Street.
BRONSON, Branch County, Mich.
Mowry, Henry P., M. D.

Minnesota.

ALEXANDRIA, Douglas County.
Peake, Francis, M.D.
CROOKSTON, Polk County.
Just, August Adolph, M.D.
DULUTH, St. Louis County.
Bowman, Frederick C., M.D., 203 Second Avenue, W.D.
FERGUS FALLS, Otter Tail County.
Welch, George Oaks, M.D.
GOOD THUNDER, Black Eearth County.
Schlesselman, John Theodore, M. D.
GRANADA, Martin County.
Hamlin, George Baldwin, M.D.
MARSHALL, Lyon County.
Renninger, John S., M.D.
MINNEAPOLIS, Hennepin County.
Aldrich, Henry C., M.D., 313 Medical Block.
Eaton, Cora E. Smith, M.D., 607 Masonic Temple.
Fisher, Anna M., M.D., 412 Nicollet Avenue.
Fisher, William H., M.D., 412 Nicollet Avenue.
Gibson, Frederick M., M.D., 602 Nicollet Avenue.
Hall, Levi, M.D., 77 Highland Avenue.
Higbee, Albert E., M.D., Masonic Temple.
Morning, David W., M.D., 604 Pillsbury Building.
Humphreys, Otis M., M.D., 1345 So. First Avenue.
Koch, Margaret, M.D., 1009 University Avenue.
Leonard, William E., M.D., 608 Nicollet Avenue.
Richardson, Oscar K., M.D., 303 Masonic Temple.
Ripley, Martha G., M.D., 40 So. Tenth Street.
Roberts, George F., M.D., 604 Pillsbury Building.
Roberts, William Burchard, M.M., Pillsbury Building.
Williamson, Alonzo P., M.D., Pillsbury Building.
RED WING, Goodhue County.
Stephens, Aaron M., M.D., 431 Fourth Street.
SLAYTON, Murray County.
Lowe, Thomas, M.D.
ST. JOHNS, Stearns County.
Dodge, John P., M.D.
ST. PAUL, Ramsey County.
Briggs, Warren S., M.D., Germania Bank Building.
Cobb, Sheridan G., M.D., 1852 Marshall Avenue.
Higbee, Chester G., M.D., 130 Western Avenue.
Man, Eugene L., M.D., 604 Endicott Arcade.
Ogden, Benjamin H., M.D., Germania Bank Building.
WINONA, Winona County.
Wilberton, Lawrence G., M.D.

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MISSOURI

Missouri.

CARTHAGE, Jasper County.
Flower, Frank W., M.D.
CHILLICOTHE, Livingston County.
Gordon, George A., M. D.
EXCELSIOR SPRINGS, Clay County.
Henry, Samuel Dwyer, M.D.
FULTON, Callaway County.
Reilly, John Armstrong, M.D.
Reilly, Walter E., M.D.
Theilmann, Emil, M.D.
GARDEN CITY, Cass County.
Schoor, Edward, M.D.
HANNIBAL, Marion County.
Waldo, Elmer E., M.D., 1052 Broadway.
KANSAS CITY, Jackson County.
Aplynne, Guy Elmont, M.D., 1214 Main Street.
Colt, Emily S., M.D., 2327 Tracy Avenue.
Cramer, William E., M.D., 1103 Main Street.
Dean, George A., M.D., 1103 Main Street.
Delap, Silas C., M.D., 1214 Main Street.
Elliot, Frank, M.D., Ridge Building.
Forster, William A., M.D., 328 Rialto Building.
Foster, William Davis, M.D., 420 West Eleventh Street.
Hudson, Thomas Howard, M.D., 1001 Prospect Avenue.
Jenney, William H., M.D., 324 West Twelfth Street.
Patterson, Joseph M., M.D., 306 Commerce Building.
Ray, William L., M.D., 1214 Main Street.
Runnels, Moses Thurston, M.D., 912 Walnut Street.
Starcke, Andrew Herman, M.D., 639 Kansas Avenue.
Van Scoyoc, Lloyd G., M.D., 1103 Main Street.
Wise, Julius C., M.D., 14 West Twelfth Street.
ST. JOSEPH, Buchanan County.
Hall, William G., M.D., 7th and Edward Streets.
Westover, Henry W., M.D., Seventh and Edward Streets.
ST. LOUIS, St. Louis County.
Blanke, Theodore F., M.D., 2239 So. Grand Avenue.
Campbell, Jas. A., 206 Mermod-Jaccard Bldg.
Chamblin, Bayles, 2427 N. Grand Avenue.
Comstock, Thomas Griswold, M.D., 3401 Washington Avenue.
Galloway, William Lincoln, M.D., 1232 Taylor Avenue.
Gibson, David M., M.D., 241 South Jefferson Street.
Gilbert, William Wallace, M.D., 314 South Jefferson Avenue.
Grundemann, J. William, M.D., 1000 W. Jefferson Avenue.
Gunderlach, Charles H., M.D., 3900 Westminster Place.
Gutherz, Lizzie Gray, M.D., 3689 Olive Street.
Harris, William John, M.D., 3514 Lucas Avenue.
Jones, W. E., 3859 Page Avenue.
Kershaw, J. Martine, M.D., 3421 Washington Avenue.

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Luytis, Carl J., M.D., 2100 Lafayette Avenue.
McElwee, L. Claude, M.D., 1113 W. Grand.
Mellies, Charles, M.D., 3825 N. Twentieth Street.
Morgan, Willis B., M.D., 4200 N. Grand Avenue.
Richardson, William C., M.D., 411 Olive Street.
Young, Willis Brock, 2344 Park Avenue.

UNIONVILLE, Putnam County.
Perry, W. H., M.D.

Montana.

BUTTE CITY, Silver Bow County.
Cowperthwaite, Joseph Erving, M.D., 9 Owsley Block.

GREAT FALLS, Black County.
Frizzell, Jno. W., M.D., 61 Central Avenue.

HELENA, Lewis and Clarke County.
Thompson, Charles S. W., M.D.

Nebraska.

CRETE, Saline County.
Foss, John B., M.D.

FAIRBURN, Jefferson County.
Clarke, Harvey L., M.D.

FREMONT, Dodge County.
Leake, Endell N., M.D., 237 West Sixth Street.

FULLERTON, Nance County.
Kinyon, Henry E, 9 Fuller Street.

HOSPITAL.
Young, Geo. Alexander, M.D., Hospital for Insane.

LINCOLN, Lancaster County.
Bailey, Benjamin F., M.D., 141 South Twelfth Street.
Dorris, Alva H., M.D., 141 South Twelfth Street.
Finney, Everett B., M.D., 1329 N. Twelfth Street.
Perky, Leonore, M.D., 148 South Twelfth Street.
Shoemaker, Charles A., M.D., 1117 L Street.

NELSON, Nuckolls County.
Cate, William A., M.D., Union Building.

NORFOLK, Madison County.
Teal, Frederick F., M.D.

OMAHA, Douglas County.
Alexander, Ernest L., 1204 N. 24th Street.
Connell, Ralph W., M.D., 1707 Dodge Street.
Edwards, Laura A., M.D., 2669 Douglas Street.
Foote, Dellizon A., M.D., 216 Paxton Block.
Hanchett, William Henry, M.D., Bee Building.
Holmes, Abby Virginia, M.D., 1512 South Twenty-sixth Street.
Wood, Orlando S., M.D., 521 N. Y. L. Building.

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ORD, Valley County.
Billings, Robert Anderson, M.D.
PLATTE CENTER, Platte County.
Benthack, Peter L., M.D.
WAHOO, Saunders County.
Way, Frank E., M.D.

Nevada.

CARSON CITY, Ormsby County.
Wagner, Philippina, M.D.

New Hampshire.

DOVER, Strafford County.
Smith, George R., M.D.
EXETER, Rockingham County.
Tuttle, Walter, M.D., Court Street.
HOLDERNESS.
Talbot, Winthrop Tisdale, M. D.
KEENE, Cheshire County.
Worcester, Frank D., M.D.
LACONIA, Belknap County.
Wiley, Rebecca W., M.D., 160 Main Street.
LAKEPORT, Belknap County.
Wrisley, John A., M.D.
LITTLETON, Grafton County.
Nobles, Wm. C., M.D., E. Main Street.
MANCHESTER, Hillsboro County.
Dodge, Charles E., M.D., 913 Elm Street.
Morse, Martin V. B., M.D.
MILFORD, New Haven County.
Hinds, Wm. H. W., 52 Nashua Street.
Putney, Willis S., Broad Street.
NASHUA, Hillsboro County.
Rounseval, Charles Sedgwick, M.D., 211 Main Street.
NEW BOSTON, Hillsboro County.
Gould, Herbert D., M.D.
PENACOOK, Merrimack County.
Roby, George F., M.D.

New Jersey.

ASBURY PARK, Monmouth County.
Ackerman, James F., M.D., 905 Grand Avenue.
Bryan, Joseph Harter, M.D., 221 Asbury Avenue.
Upham, Ella Prentiss, M.D.
ATLANTIC CITY, Atlantic County.
Baily, Alfred W., M.D., 1809 Pacific Avenue.
Balliet, Lorenzo Dow, M.D., 1001 Atlantic Avenue.

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NEW JERSEY

Cromwell, Lydia Herts, M.D., Galan Hall.
Crosby, George W., M.D., 716 Atlantic Avenue.
Fleming, John R., M.D., 1903 Pacific Avenue.
Gardiner, William G., M.D., 158 South Penn Avenue.
Lyon, Melvin S., M.D., 716 Atlantic Avenue.
Miller, Mary, M.D.
Munson, Milton L., M.D., 1503 Pacific Avenue.
Sooy, Walter C., M.D., 1921 Pacific Avenue.
Westney, Alfred W., M.D., 1302 Pacific Avenue.
Youngman, Maurice D., M.D., 1618 Pacific Avenue.

ATLANTIC HIGHLANDS, Monmouth County.
Fay, George De Witt, M.D., 23 Bay View Avenue.

BELLEVILLE, Essex County.
Cyphers, Edward O., M.D., 378 Washington Avenue.

BELVIDERE, Warren County.
Lefferts, Franklin P., M.D.

BLOOMFIELD, Essex County.
Bull, William H. H., M.D.

BRIDGETON, Cumberland County.
Streets, Jacob G., M.D.

BURLINGTON, Burlington County.
Shreve, Joseph, M.D.

CAMDEN, Camden County.
Artz, Jerome L., M.D., 3000 Westfield Avenue.
Griscom, L. E., M.D., 919 South Fifth Street.
Gumbrecht, Oscar Leonard, M.D., 615 Market Street.
Hadley, Charles F., M.D., 3320 Federal Street.
Howard, Erving Melville, M.D., 401 Linden Street.
McGeorge, Wallace, M.D., 521 Broadway.
Middleton, M. F., M.D., 423 Market Street.
Moslander, William S., M.D., 837 Penn Street.
Woodward, George D., M.D., 211 Broadway.

EAST ORANGE, Essex County.
Arcularius, Philip E., M.D., 52 Chestnut Street.
Groves, Charles A., M.D., 303 Main Street.
West, Edwin, M. D., 6 North Walnut Street.

ELIZABETH, Union County.
Brown, Stanley R., M.D., 287 North Broad Street.

ENGLEWOOD, Bergen County.
Best, George B., M.D.

HACKENSACK, Bergen County.
Adams, Charles F., M.D., 229 Union Street.
Harris, Nelson A., 339 Union Street.

HADDONFIELD, Camden County.
Williams, Franklin E., M.D.

HOBOKEN, Hudson County.
Clausen, Bernard, M.D., 736 Garden Street.
Rabe, Jr., Rudolph Frederick, M.D., 26 Columbia Terrace, Station I.

IRVINGTON, Essex County.
Bruce, Ida F., M.D., 1156 Springfield Avenue.

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JERSEY CITY, Hudson County.
Everett, Ambrose S., M.D., 37 Garrison Avenue.
Fletcher, Zachary P., M.D., 23 Cottage Street.
Hoffman, James, M.D., 461 Jersey City.
Klein, A. Katharine, 172 Bowers Street.
Nevin, J. Lawrence, M.D., 158 Bowers Street.
Opdyke, Levings A., M.D., 55 Clinton Avenue.
MADISON, Morris County.
Scarborough, Charles W., M.D., 19 Wilmer Place.
MATAWAN, Monmouth County.
Straughn, Clinton Clement, M.D.
MONTCLAIR, Essex County.
Butler, Clarence W., M.D., 35 Fullerton Avenue South.
Foster, Herbert W., M.D., 27 South Fullerton Avenue.
Geddes, Annie Lowe, M.D., 12 S. Fullerton Avenue.
MOORESTOWN, Burlington County.
Mattson, Alfred S., M.D.
MORRISTOWN, Morris County.
Connett, George Cramer, M.D., 45 Washington Street.
Uebelacker, Arman E., M.D., 109 South Street.
MOUNT HOLLY, Burlington County.
Branin, John W., M.D., 33 Washington Street.
Van Derveer, George W., M.D.
MULLACA, Gloucester County.
Carr, Henry H., M.D.
NEWARK, Essex County.
Baldwin, Edward Hill, M.D., 77 Clinton Avenue.
Dennis, Laban, M.D., 30 Central Avenue.
Harman George W., M.D., 900 Broad Street.
Muller, Joseph H., M.D., 133 Littleton Avenue.
Sleght, B. H. B., M.D., 31 Lincoln Park.
Wintsch, Carl Herman, M.D., 271 Fairmount Avenue.
NEW BRUNSWICK, Middlesex County.
Applegate, G. T., M.D., 25 Livingston Avenue.
ORANGE, Essex County.
Moffat, Edgar V., M.D., 476 Main Street.
Richard, George Herbert, M.D., 30 Highland Avenue.
Wakeley, William A., 420 So. Main Street.
PASSAIC, Passaic County.
Church, Charles A., M.D., 128 Prospect Street.
DeBaun, Edwin, M.D., 142 Main Street.
PATERSON, Passaic County.
Carr, Ada, M.D., 125 Vreeland Avenue.
Kinne, Porter S., M.D., 9 Church Street.
Kinne, Theodore Y., M.D., 9 Church Street.
Vreeland, Frank Dinwiddie, M.D., 316 Broadway.
Willard, Harry Sterns, M.D., 197 Ellison street.
PLAINFIELD, Union County.
Davis Thomas S., M.D., 603 Park Avenue.
Rushmore, Edward, M.D., 429 Park Avenue.

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PRINCETON, Mercer County.
Kline, Andrew K., M.D.
RED BANK, Monmouth County.
Garrison, Biddle Hiles, M.D., 23 Monmouth Street.
RIDGEWOOD, Bergen County.
Ockford, George M., M.D., 3 Oak Street.
SUMMIT, Union County.
Burling, J., M.D.
VINELAND, Cumberland County.
Foote, Theodore, M.D., 636 Wood Street.
WASHINGTON, Warren County.
McKinstry, Frank P., M.D.
WEST HOBOKEN, Hudson County.
McClellan, David, M.D., 104 Clinton Avenue.
WOODBURY, Gloucester County.
Campbell, Duncan, M.D.
Parker, T. Elwood, M.D.

New York.

ADAMS, Jefferson County.
Nickelson, W. H., M.D., A. D. Ripley Block.
ALBANY, Albany County.
Cox, Edward Gilbert, M.D., 261 State Street.
Cox, Frederick Joseph, M.D., 109 State Street.
Cox, George A., M.D., 80 S. Swan Street.
Dowling, Joseph Ivimey, M.D., 233 State Street.
Gorham, George E., M.D., 160 Hamilton Street.
Milbank, William E., M.D., 111 State Street.
Nead, William M., M.D., 205 State Street.
Van Loon, Arthur Burton, M.D., 50 Eagle Street.
ATTICA, Wyoming County.
Gifford, Willis B., M.D.
BALLSTON SPA, Saratoga County.
Royal T. Cook, M.D., 101 Milton Avenue.
BATAVIA, Genesee County.
Hutchins, Horace S., M.D.
Le Seur, John Wesley, M.D.
BELMONT, Alleghany County.
Hardy, William Jones, M.D.
Paul, William Kendall, M.D.
BINGHAMTON, Broome County.
Bailey, De Witt P., M.D., 507 Chenango Street.
Corwin, Elizabeth, M.D., 104 Main Street.
Jenkins, George Hamilton, M.D., 139 Main Street.
Martin, Lynn A., M.D., 74 Exchange Street.
Snyder, Edward E., M.D.
Ward, Charles Austin, M.D.
BROOKLYN, Kings County (New York City).
Allen, Herbert C., M.D., 310 Clermont Avenue.

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BROOKLYN, NEW YORK

Aten, William Hy., M.D., 100 Greene Avenue.
Baker, Jennie Van Holland, M.D., 512 Bedford Avenue.
Baylies, B. L. B., M.D., 418 Putnam Avenue.
Bierbauer, Bruno W., M.D., 47 Pierrepont Street.
Blackman, William W., M.D., 519 Clinton Avenue.
Bormann, Alfred, M.D., 271 Putnam Avenue.
Brown, Charles A., M.D., 155 Halsey Street.
Brownell, De Ette, M.D., Memorial Hospital.
Bryant, William Cullen, M.D., 64 Greene Avenue.
Butler, William M., M.D., 507 Clinton Avenue.
Chapin, Edward, M.D., 21 Schermerhorn Street.
Cort, Lottie A., M.D., 89 Division Avenue.
Dickie, Perry, M.D., 17 Schermerhorn Street.
Eliott, Amos H., M.D., 480 Monroe Street.
Fincke, Bernhardt, M.D., 122 Livingston Street.
Fiske, Edwin Rodney, M.D., 140 Dean Street.
Fiske, William M. L., M.D., 140 Dean Street.
Given, James B., M.D., 463 Ninth Street.
Hasbrouck, Everett, M.D., 389 Fourth Street.
Hayward, Arthur, M.D., 426 Franklin Avenue.
Hopper, Magnus Tate, M.D., 46 So. Oxford Street.
Jeffery, George Clinton, M.D., 343 Jefferson Avenue.
Johnston, Charles L., M.D., 467 Vanderbilt Avenue.
Keep, J. Lester, M.D., 460 Clinton Avenue.
Knapp, Herbert J., M.D., 287 So. Fifth Street.
Lazarus, George F., M.D., 10 Caton Avenue.
Lines, Mary Louise, M.D., 344 Washington Avenue.
Lutze, Frederick H., M.D., 212 Keap Street.
Minton, Henry Brewster, M.D., 165 Joralemon Street.
Moffat, John L., M.D., 1136 Dean Street.
Monmonier, Julius L., M.D., 480 Classon Avenue.
Muncie, Libbie Hamilton, M.D., 119 Macon Street.
Pierron, Henry J., 438 Greene Street.
Pierson, William Horton, M.D., 101 McDonough Street.
Rankin, John E., 1185 Dean Street.
Richardson, B. M., M.D., 151 Milton Street.
Ritch, Orando S., M.D., 337 Macon Street.
Robinson, Nathaniel, M.D., 89 Halsey Street.
Schall, John H., M.D., 141 St. Mark's Avenue.
Schenck, Herbert Dana, M.D., 241 McDonough Street.
Simmons, Daniel, M.D., 1188 Dean Street.
Simon, Samuel H., M.D., 195 Garfield Place.
Smith, Sidney E., M.D., 77 Arlington Avenue.
Talmage, Samuel, M.D., 22 Schermerhorn Street.
Von Der Luhe, Amelia D. F., M.D., 801 Driggs Avenue.
Van Schoonhoven, Cornelius S., M.D., 1060 Lafayette Avenue.
Warner, Alton G., M.D., 19 Schermerhorn Street.
Wiggins, Theodore C., M.D., 12 Verona Place.
Winchell, Walter B., M.D., 137 Berkeley Place.

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BUFFALO, Erie County.
Baethig, Henry, M.D., 350 Pennsylvania Street.
Chadwick, John Gartside, M.D., 382 Franklin Street.
Cook, Joseph T., M.D., 636 Delaware Avenue.
Erb, Peter, M.D., 32 Palace Arcade.
Lewis, F. Park, M.D., 454 Franklin Street.
Lewis, Frederick Daniel, M.D., 188 Franklin Street.
Martin, Truman J., M.D., 245 North Street.
Maycock, Burt J., M.D., 33 Allen Street.
Miller, John, M.D., 48 St. John's Place.
Moseley, George Thomas, M.D., 202 Delaware Avenue.
Seaman, Clayton Welch, 232 Hoyt Street.
Stumpf, Daniel B., M.D., 693 Ellicott Street.
Wage, John F., M.D., 414 Seneca Street.
Wilcox, De Witt G., M.D., 597 Elmwood Avenue.

CANDOR, Tioga County.
Holly, Eugene DeAlton, M.D., Owego and Main Streets.

CANTON, St. Lawrence County.
Williams, Frank Fay, M.D., 6 Goodrich Street.

CARTHAGE, Jefferson County.
Robinson, Franklin E., M.D.
Simonds, E. A., M.D.

CHAUTAUQUA, Chautauqua County.
Robbins, A. Jerome, M.D. (also Mayville).

COOPERSTOWN, Otsego County.
Harrison, Herbert Alexander, M.D.

CORTLAND, Cortland County.
Nash, Eugene B., 28 Clinton Avenue.
Spalding, Julia H., M.D., 39 N. Main Street.

DELHI, Delaware County.
Schumann, Carl, M.D.

DEPOSIT, Broome County.
Mead, Walter Glover, M.D.

DUNKIRK, Chautauqua County.
Rieger, Joseph, M.D., 9 W. Fourth Street.

EAST BLOOMFIELD, Ontario County.
Partridge, Barton Scott, M.D.

ELMIRA, Chemung County.
De Camp, Frank Hurd, 410 William Street.
Eddy, Ermina Catharine, M.D., 500 William Street.
Jenks, Edwin Brown, M.D., 300 West Church Street.

FAIRPORT, Monroe County.
Clapp, Wesley F., M.D.

FREDONIA, Chautauqua County.
Couch, Asa S., M.D.
Evans, Albert J., M.D.

FRIENDSHIP, Alleghany County.
Williams, Bemesley, M.D.

GENESEO, Livingston County.
Southall, Edw. W., M.D.

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NEW YORK

GENEVA, Ontario County.
Hopkins, William Wilder, M.D., 114 Main Street.
GLENS FALLS, Warren County.
Birdsall, Stephen T., M.D.
Smith, Melvin D., M.D., 47 Ridge Street.
GLOVERSVILLE, Fulton County.
Garnsey, William Smith, M.D., 93 W. Main.
Hill, Emily L., M.D., 30 So. Main Street.
GOSHEN, Orange County.
Seward, Frederick W., M.D., Main Street.
Seward, Frederick W., Jr., M.D.
GOWANDA, Cattaraugus County.
Adams, G. Francis, M.D.
Arthur, Daniel H., M.D.
Potter, Clarence Albert, M.D.
Zwetsch, Jno. D., M.D., Main Street.
HAMILTON, Madison County.
Gifford, Gilbert L., M.D.
Wilcox, George W., M.D., Eaton Street.
HOMER, Cortland County.
Pratt, Lester M., M.D.
HONEOYE FALLS, Monroe County.
White, Benjamin R., M.D.
HOOSICK FALLS, Rensselaer County.
Putnam, William B., M.D., 34 Wilder Avenue.
HUNTINGTON, Suffolk County.
Sword, George P., M.D.
ITHACA, Tompkins County.
Beanman, Charles P., M.D.
Besemer, Howard Burhause, M.D., Osborn Block.
Besemer, Martin, M.D., 116 East State Street.
Crum, Harry Herbert, M.D., 212 Hazen Street.
JAMAICA, Queens County.
Belden, Charles K., M.D., 28 Clinton Avenue.
Macfarland, Ralph L., M.D., 53 Clinton Avenue.
JAMESTOWN, Chautauqua County.
Ormes, Francis D., M.D.
Rice, Alvin B., M.D., 117 Fairmount Avenue.
KEESEVILLE, Essex County.
Pope, Willis G., M.D.
LEROY, Genesee County.
Skinner, Scott W., M.D.
LIBERTY, Sullivan County.
Deady, Howard Percy, M.D.
LOCKPORT, Niagara County.
Hurd, S. Wright, M.D., 73 Main Street.
MAMARONECK, Westchester County.
Hall, Mathew J., M.D.
Humphrey, Frank A.
Montgomery, R. W., M.D.

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NEW YORK

MAYVILLE.
Robbins, A. Jerome.
MEDINA, Orleans County.
Damon, G. J.
Swett, Emily F., M.D.
MIDDLETOWN, Orange County.
Ashley, Maurice C., M.D.
Everett, Edward A., M.D., State Hospital.
Francisco, David E., M.D., State Hospital.
Woodman, Robert C., M.D., State Hospital.
MOUNT VERNON, Westchester County.
Ives, Nathaniel Holmes, 145 Second Avenue.
Jones, Henry C., M.D., 220 S. First Avenue.
NEW BRIGHTON, Richmond County.
Conklin, Frances C. Donovan, M.D., 48 Westervelt Avenue.
NEWBURGH, Orange County.
Jacobson, Frank Aikens, 209 Grand Street.
Mitchell, John J., M.D.
NEW ROCHELLE, Westchester County.
Finch, Edwin W., M.D., Center Avenue and Prospect Street.
Roberts, David J., M.D.
NEW YORK, New York County.
Allen, J. Wilford, M.D., 110 W. Twelfth Street.
Allen, Paul, M.D., 3 E. Forty-eighth Street.
Allen, Timothy Field, M.D., 3 E. Forty-eighth Street.
Ambler, John Edgar, M.D., 134 E. Nineteenth Street.
Arschagouni, John, M.D., 727 Lexington Avenue.
Austin, A. Eugene, M.D., 17 E. Sixty-sixth Street.
Bagg, Clinton L., M.D., 26 West Forty-sixth Street.
Baldwin, Jared G., M.D., 8 E. Forty-first Street.
Barker, Caleb, Jr., M.D., Hahnemann Hospital.
Baruch, Solomon, M.D., 1135 Lexington Avenue.
Bassett, John S., M.D., 11 W. Thirty-first Street.
Beckwith, S. R., M.D., 170 Fifth Avenue.
Bennett, James A., M.D., 4 Irving Place.
Bergeron, Emma G., M.D., 239 Lenox Avenue, and Stamford, Conn.
Berghaus, Alexander, M.D., 138 Sixty-first Street.
Bingham, Anson Holden, M.D., 113 W. Eighty-seventh Street.
Bishop, William H., M.D., 56 W. Forty-eighth Street.
Bissell, Arthur F., M.D., 80 Wall Street.
Bond, Mary E., M.D., 122 Lexington Avenue.
Boyle, Charles C., M.D., 49 W. Thirty-seventh Street.
Boynton, Frank H., M.D., 36 W. Fiftieth Street.
Brewster, George Franklin, M.D., Metropolitan Hospital.
Broeser, Henry Valentine, M.D., Flower Hospital, Avenue A and Sixty-third Street.
Brown, M. Belle, M.D., 30 W. Fifty-first Street.
Buchanan, T. Drysdale, M.D., 328 West Twenty-fourth Street.
Buckholz, Louise Z., M.D., 73 East Eighth Street.
Carleton, Bukk G., M.D., 75 W. Fiftieth Street.

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NEW YORK CITY

Charles, Emily C., M.D., 51 W. 127th Street.
Chase, J. Oscoe, M.D., 214 E. Fifty-third Street.
Clark, Byron G., M.D., 162 W. 122d Street.
Clawson, Frank A., M.D.
Coleman, Daniel E. S., M.D., Metropolitan Hospital.
Crump, Walter Gray, M.D., 693 Madison Avenue.
Danforth, Loomis L., M.D., 59 W. Fifty-second Street.
Davies, Thomas F., M.D., 359 W. 116th Street.
Davis, John E. L., M.D., 743 Madison Avenue.
Deady, Charles, M.D., 110 W. Forty-eighth Street.
Dearborn, Frederick Myers, M.D., 146 West Fifty-seventh Street.
Dearborn, Henry M., M.D., 146 W. Fifty-seventh Street.
Delabarre, Walter E., M.D., 222 W. Fifty-ninth Street.
Demarest, John H., M.D., 59 W. 126th Street.
Deschere, Martin, M.D., 334 W. Fifty-eighth Street.
Dieffenbach, William H., M.D., The "Rockingham," S. E. Cor. Broadway and Fifty-sixth Street.
Dillingham, Thomas Manley, M.D., 8 W. Forty-ninth Street.
Dillow, George Morris, M.D., "The Rutland," 57th St. and Broadway.
Doremus, Widmar E., M.D., Flower Hospital.
Doughty, Francis E., M.D., 512 Madison Avenue.
Dowe, Frank LeC., M.D., S. Boulevard and Briggs Avenue.
Dowling, John W., M.D., 116 W. Forty-eighth Street.
Drury, Alfred, M.D., 457 West 147th Street.
Dunlevy, Rita, M.D., 328 W. Fifty-seventh Street.
Edwards, Mary L., M.D., 19 West Forty-sixth Street.
Ermentraut, John P., M.D., 44 Seventh Street.
Franklin, Edward D., M.D., 325 W. Fourteenth Street.
Fobes, Joseph Henry, M.D., 2 Riverview Terrace.
Garrison, John B., M.D., 111 E. Seventieth Street.
Gennerich, Charles, M.D., 181 E. Sixty-Fourth Street.
Gilbert, Charles E., M.D., 323 W. Twenty-third Street.
Guernsey, Egbert, M.D., 180 W. Fifty-ninth Street.
Hallett, G. DeWayne, M.D., 132 W. Eighty-first Street.
Hamlin, Frederick William, M.D., 130 W. Forty-eighth Street.
Hardy, Samuel Olin, M.D., 912 West End Avenue.
Hathaway, Henry S., M.D., 146 W. Ninety-second Street.
Helfrich, Charles H., M.D., 42 Fifth Avenue.
Helmuth, William Tod, M.D., 26 E. Sixty-second Street.
Hertz, Sue Emma, M.D., 102 W. Forty-fourth Street.
Hollister, Frederick Kellogg, M.D., 59 E. Fifty-second Street.
Honan, William Francis, M.D., Sherman Square Hotel.
House, Wallace Belding, M.D., 203 W. 113th Street.
Howard, Clarence C., M.D., 57 West Fifty-first Street.
Howe, J. Morgan, M.D., 58 W. Forty-seventh Street.
Hoyt, Eugene F., M.D., 39 W. Fifty-eighth Street.
Hunt, Dwight B., M.D., 159 Madison Avenue.
Hutchinson, John, M.D., 78 E. Fifty-fifth Street.
Keep, Caroline J. Yeomans, M.D., 308 W. Thirty-sixth Street.
Kellogg, Edwin M., M.D., 155 Madison Avenue.

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King, William Harvey, M.D., 64 W. Fifty-first Street.
Laidlaw, George Frederick, M.D., 58 W. 53d Street.
Land, Joseph Foster, M.D., 130 W. 126th Street.
Leal, Malcolm, M.D., 107 W. Forty-eighth Street.
Leao, Francisco Garcia P., M.D., 17 State Street.
Lewis, Henry M., M.D., "Florence," 18th Street and Fourth Avenue.
Lund, Frederick Albert, M.D., 512 Madison Avenue.
MacBride, Nathaniel Louis, M.D., 158 W. Forty-third Street.
Macy, Charles Seely, M.D., 103 W. 71st Street.
Maeder, John G., M.D., 304 E. 120th Street.
McDonald, William O., M.D., 9 W. Sixty-Eighth Street.
McDowell, Charles, M.D., 110 W. Twelfth Street.
McDowell, George W., M.D., 542 Fifth Avenue.
McKnight, William Clark, M.D., 3 Mt. Morris Park, W.
McMichael, Arkell R., M.D., 969 Madison Avenue.
Mills, Walter Sands, M.D., 154 W. 119th Street.
Miner, Frederick Cohoon, M.D., 1134 Forest Avenue.
Mossman, Nathan A., M.D., St. Andrews Hotel.
Muller, Charles W., M.D., 209 E. Eighty-seventh Street.
Munson, Edwin S., M.D., 16 W. Forty-fifth Street.
Nielson, Howard Stout, M.D., 46 W. Forty-eighth Street.
Norton, Arthur B., M.D., 16 W. Forty-fifth Street.
Nott, Frederick J., M.D., 554 Madison Avenue.
O'Connor, Joseph T., M.D., W. Forty-second Street.
Ogden, Edwin G., M.D., 10 E. Thirty-second Street.
Ostrom, Homer I., M.D., 42 W. Forty-eighth Street.
Palmer, A. Worrall, M.D., 210 W. 57th Street.
Palmer, Miles W., M.D., 235 E. Eighteenth Street.
Pardee, Ensign B., M.D., 74 W. Forty-eighth Street.
Patchen, George H., M.D., 20 W. Fifty-ninth Street.
Perkins, Chas. Winfield, Metropolitan Hospital.
Pettet, Isabella Margaretta, M.D., 308 E. Fifteenth Street.
Pierce, Willard I., M.D., 64 W. 126th Street.
Porter, Eugene H., M.D., 181 W. Seventy-third Street.
Powel, Milton, M.D., 163 W. Seventy-sixth Street.
Rankin, Egbert G., M.D., 226 W. Fifty-ninth Street.
Reynolds, Warren U., M.D., 320 Manhattan Avenue.
Richardson, Andrew J., M.D., 39 E. Eighty-third Street.
Richardson, George W., M.D., 138 E. Seventy-ninth Street.
Roberts, George W., M.D., "The Cordovia," 170 W. Fifty-ninth Street.
Rudderow, Edward Douglas, M.D., 145 W. Eighty-eighth Street.
Russell, H. Everett, M.D., 30 E. Seventy-fourth Street.
Schley, James Montford, M.D., 32 W. Forty-ninth Street.
Scott, William H., M.D., 104 W. Forty-fourth Street.
Seward, John Perry, M.D., 200 W. Seventieth Street.
Shelton, George G., M.D., 521 Madison Avenue.
Shepard, George Andrew, M.D., "The Glenmore," 7th Ave. and 55th St.
Sherman, Le Roy B., M.D., 355 W. Fourteenth Street.
Simpson, Edwin Daniel, M.D., 320 W. 115th Street.
Smith, St. Clair, M.D., 25 W. Fiftieth Street.

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Smith, T. Franklin, M.D., 264 Lenox Avenue.
Stewart, George Taylor, M.D., Rutland, Broadway and 57th Street.
Stewart, Ralph Alexander, M.D., Flower Hospital, Avenue A and Sixty-third Street.
Storer, John Hudson, M.D., 30 Edgecombe Avenue.
Swift, Edward P., M.D., 170 W. Eighty-eighth Street.
Teets, Charles E., M.D., 56 W. Thirty-ninth Street.
Thompson, John H., M.D., 36 E. Thirtieth Street.
Thompson, Virgil, M.D., 32 W. Twenty-first Street.
Townsend, Irving, M.D., 67 W. Forty-sixth Street.
Tuttle, Edward G., M.D., 61 W. Fifty-first Street.
Tyler, George E., M.D., 113 W. 126th Street.
Van den Burg, William H., M.D., 32 W. Forty-ninth Street.
Vehslage, Samuel H., M.D., 117 W. Forty-third Street.
Ver Nooy, Charles, M.D., 146 W. Sixty-fourth Street.
Wait, Phœbe J. B., M.D., 412 Ninth Avenue.
Wetmore, John McE., M.D., 43 W. Fifty-fourth Street.
Wilcox, Sydney F., M.D., 51 W. Fifty-second Street.
Wilder, Louis de V., M.D., 55 W. Thirty-third Street.
Wilson, John E., 23 E. Forty-fifth Street.
Woodward, A. M., M.D., 128 W. Thirteenth Street.

NIAGARA FALLS, Niagara County.
Hodge, William H., M.D., 324 Buffalo Avenue.
Hough, Walter D., M.D., 635 Main Street.

NORTH GRANVILLE, Washington County.
Spoor, David E., M.D.

NORTH TARRYTOWN, Westchester County.
Brown, Edward V., M.D.

NORWICH, Chenango County.
Roper, F. E., M.D., 73 Broad Street.

NORWOOD, St. Lawrence County.
Sumner, Charles Oliver, M.D., 4 Park Street.

NYACK, Rockland County.
Couch, Lewis B., M.D.

OGDENSBURG, St. Lawrence County.
Bell, W. N., M.D., 6 Greene Street.

OSWEGO, Oswego County.
Richards, Llewellyn B., M.D.

OWEGO, Tiago County.
Greenleaf, John T., M.D.
Hamblin, Frank Milton, M.D., "Glenmary."
Hyde, Louis D., M.D., 239 Main Street.

OXFORD, Chenango County.
Ganow, George J., M.D., 21 Washington Avenue.
Miller, Robert Emmett, M.D.

PANAMA, Chautauqua County.
Young, Albert D., M.D.

PATERSON, Putnam County.
Birdsall, Thomas P., M.D.

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PEEKSKILL, Westchester County.
Mason, Perley Hugh, M.D., 734 South Street.
Otis, John Calhoun, M.D., 319 Mill Street.
PERRY, N. Y.
Brownell, John M., M.D.
PIKE, Wyoming County.
Andrews, Lemar M., M.D.
PORTCHESTER, Westchester County.
White, John C., M.D., N. Main Street.
POUGHKEEPSIE, Dutchess County.
Lane, Charles E., M.D., 289 Mill Street.
RANDOLPH, Cattaraugus County.
Babcock, Archibald H., M.D.
RICHFIELD SPRINGS, Otsego County.
Getman, Norman, M.D.
Ward, Henry A.
ROCHESTER, Monroe County.
Adams, Reuben A., M.D., 46 North Fitzhugh Street.
Bachman, George A., M.D., South Avenue.
Biegler, Joseph A., M.D., 58 South Clinton Street.
Bissell, Elmer Jefferson, M.D., 75 South Fitzhugh Street.
Button, Lucius L., M.D., 45 South Clinton Street.
Collins, Newton M., M.D., 43 East Avenue.
Haywood, Julia F., M.D., 612 West Avenue.
Hoyt, Herbert W., 75 South Fitzhugh Street.
Keegan, William A., M.D., 40 South Clinton Street.
Lee, John Mallory, M.D., 121 Lake Avenue.
MacCallum, John H., M.D., 408 Monroe Avenue.
Parsons, Thomas, M.D., 213 Alexander Street.
Powelson, Arthur S., M.D., Alexander Street.
Ricker, Marcena S., M.D., 58 Lorimer Street.
Snell, William M.
Sumner, Charles R., M.D., 33 South Clinton Street.
Wolcott, Edwin H., M.D., 57 South Union Street.
ROME, Oneida County.
Southwick, Augustus B., M.D., 107 West Liberty Street.
SALT POINT, Dutchess County.
Angell, Milton H., M.D.
SARANAC LAKE, Franklin County.
Hallock, J. Henry, M.D.
SARATOGA SPRINGS, Saratoga County.
Ayres, Emma F. Macomber, M.D., 69 Caroline Street.
SCHENECTADY, Schenectady County.
Faust, Louis, M.D.
Faust, William P., M.D., 22 Jay Street.
SYRACUSE, Onondaga County.
Candee, J. Willis, M.D., 501 Fayette Park.
Hartman, W. Louis, M.D., "The Kenyon," 601 Warren Street.
Keeler, E. Elmer, M.D., 423 East Jefferson Street.
Kinne, Arthur B., M.D., 410 Fayette Park.

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Kinne, E. Olin, M.D., 516 Warren Street.
Sheldon, Jay W., M.D., 501 Fayette Park.
Sherwood, Bradford Wyckoff, M.D., 1117 S. Salina Street.

TROY, Rensselaer County.
Bloss, Jabez P., M.D., 108 Second Street.
Coburn, Edward S., M.D., 91 Fourth Street.

UTICA, Oneida County.
Alliaume, Charles Ed., M.D., 221 Genesee Street.
Bruce, Augustus H., M.D., Gardner Building.
Haines, Charles Ter Bush, M.D., 43 Gardner Building.
Terry, Marshall O., M.D., 196 Genesee Street.
Watson, William H., M.D., 270 Genesee Street.

WALTON, Delaware County.
Mowbray, J. Lincoln, M.D., 9 Benton Avenue.
St. John, A. H., M.D.

WARSAW, Wyoming County.
Slaught, James E., M.D.

WARWICK, Orange County.
Beattie, Joseph Hoyt.
Cummins, Frank M., M.D.

WATERVILLE, Oneida County.
Dean, Louis W., M.D.
Leeds, Frank R., M.D., Main Street.

WESTFIELD, Chautauqua County.
Seymour, George W., M.D., North Portage, No. 40.

WHITE PLAINS, Westchester County.
Birch, Charles E., M.D.
Haight, Alfred M., M.D., 19 N. Broadway.
Kingsley, O. D., M.D., 19 N. Broadway.

YONKERS, Westchester County.
Fay, Russell P., M.D., 165 Warburton Avenue.
Keith, Horace G., M.D., 317 South Broadway.
Phillips, R. Oliver, M.D., 257 Warburton Avenue.
Trotter, Richard R., M.D., 189 Warburton Avenue.

North Carolina.

PINE BLUFF.
Grant, Wm. H., M.D.

North Dakota.

FARGO, Cass County.
McHarrie, William, M.D.
Vidal, James W., M.D.

JAMESTOWN, Stutsman County.
De Puy, Richard G., M.D.

LEONARD, Cass County.
Hobart, W. F., M.D.

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Ohio.

ADA, Harding County.
Ames, Charles S., M.D.
AKRON, Summit County.
Carter, Rollin Bert, M.D., 106 Adalph Avenue.
Gauffield, Edwin J., M.D., 518 So. Market.
Kapp, Michael Wm., 32 Central Office Building.
Wilson, William, M.D., 121 Bates Street.
ALLIANCE, Stark County.
Haggart, George Benjamin, M.D., 153 East Main Street.
ASHTABULA, Ashtabula County.
Griggs, O. P., 42 Center.
Siegfried, John P., M.D.
BELLEFONTAINE, Logan County.
Wilson, Joseph H., M.D.
Young, Jas. W.
BOWLING GREEN, Wood County.
Whitehead, J. H., M.D., 43 Church Street.
CADEZ, Harrison County.
Lyons, Matilda Jamison, M.D.
CAMBRIDGE, Guernsey County.
Wells, Levy C., M.D., 719 Wheeling Avenue.
CANTON, Stark County.
House, Charles Everett, M.D.
Rizer, Alfred L., 318 North Cleve Avenue.
CARDINGTON, Morrow County.
White, Florence R. Smith., M.D.
CHILLICOTHE, Ross County.
Gibbs, Frank L., M.D., 88 W. Second.
Hoyt, Charles, M.D.
CHIPPEWA LAKE, Uledina County.
Dillman, Daniel, M.D.
CHICAGO, Huron County.
Metcalf, Hiram Hulbert, M.D.
CINCINNATI, Hamilton County.
Brickley, Laura C., M.D., Chase and Hamilton Avenues.
Buck, Jirah D., M.D., 124 West Seventh Street.
Crank, C. D., M.D., 106 Auburn Avenue.
Crawford, John M., M.D., Auburn Avenue.
Geiser, S. R., M.D., 1511 Baymiller Street.
Geohegan, William A., M.D., 918 Hawthorne Avenue, Price's Hill.
Georgi, Sophia E., M.D., 1634 Pullan Sta. A.
Kirk, Ellen Maria, M.D., 107 Odd Fellows Temple.
Kilgour, Peter T., Hamilton Avenue, Cincinnati.
Leevey, Marian E. Kyle, M.D., 513 W. Seventh Street.
McCormick, A. L., M.D., 3110 Woodburn Avenue.
Meade, Stephen Johnson D., M.D., 18 W. Seventh Street.
Meader, Lee Douglas, M.D., 2651 Gilbert Avenue, Walnut Hill.
Minon, Mary E., M.D., Burch Avenue, Hyde Park.
Pauly, C. A., M.D., Union Trust Building.
Phillips, Lincoln, M.D., 1104 McMillan Street.

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Reid, Robert G., M.D., Union Trust Building.
Stewart, Thos. M., M.D., 704 Elm Street.
Walton, Charles E., M.D., 716 John Street.
Wiggers, Henry H., M.D., 529 Everett Street.

CIRCLEVILLE, Pickaway County.

Peters, Wilson L., M.D.

CLEVELAND, Cuyahoga County.

Adams, Ernest O., 1617 Wilson Avenue.
Baldinger, Arthur F., M. D., 687 The Arcade.
Barton, Pauline Heidet, M.D., Rose Building.
Baxter, Harris H., M.D., 275 Prospect Street.
Beckwith, D. H., M.D., 94 Dorchester Street.
Biggar, Hamilton F., M.D., 260 Euclid Avenue.
Bishop, Hudson D., M.D., 143 Euclid Avenue.
Cummer, Robt. J., 396 Bolton Avenue.
Frost, Herbert L., M.D., 10 Hayward.
Goddard, John R., 684 Hough Avenue.
Hendrix, John Oliver, Castle Building.
Handmacher, David, 2260 Broadway.
Hoover, Julia E., 145 Taylor Street.
Horner, J. Richey, M.D., 275 Prospect Street.
Hunt, Ella Grace, M.D., 608 West Eighth Street.
Jend, Gustav Adolph, 1194 Sayne Avenue.
Jewitt, Edward H., M.D., 484 Arcade.
Jones, Gaius J., M.D., Caxton Building.
Jones, Geo. W., 310 Caxton Building.
Kimmel, Benj. B., M.D., 822 Rose Building.
Kraft, Frank, M.D., 57 Bell Avenue.
Lewis, Fred Lyman, 1854 Pearl Street.
Lytle, Joseph Allgyer, 718 Rose Building.
Nicholas, George D., M.D., Huron St. Hospital.
Nobles, Newmann T. B., 3176 Euclid Avenue.
Palmer, Orren A., M.D., 26 Streator Avenue.
Parsons, Katharine, M.D., 914 Prospect Street.
Paterson, William, M.D., 1419 Lorain Street.
Pomeroy, Harlan, M.D., 116 Ingleside Avenue.
Quay, George H., M. D., 820 Rose Building.
Quilliams, F. F., M. D., 2802 Euclid Avenue.
Richardson, Francis Newton, M.D., 83 Jennings Avenue.
Roper, Pulaski B., M. D., 822 Rose Building.
Rust, Edwin G., M.D., 29 Euclid Avenue.
Sanders, John C., M.D., 608 Prospect Street.
Sanders, J. Kent, M. D., 608 Prospect Street.
Schneider, Adolph Benedict, M. D., 520 Rose Building.
Stephens, James A., M. D., 230 Euclid Avenue.
Stone, Martha M., M. D., 914 Prospect Street.
Thego, Wm. Edgar, 1463 Cedar Avenue.
Turrill, Geo. Edward, 176 Euclid Avenue.
Van Norman, H. B., M.D., 289 Pearl Street.
Waite, Kent B., M. D., 710 Rose Building.
Waltz, Alvin L., 526 Prospect Street.

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Wilkins, Geo. R., 568 W. Madison Avenue.
Wood, James C., M.D., 820 Rose Building.

COLUMBUS, Franklin County.
Barbee, Benjamin I., M.D., 60 East Broad Street.
Carpenter, Willard B., M.D., 657 North High Street.
Connell, Robert Wilkie, M.D., 427 East Long Street.
Hunt, Maurice P., M.D., 200 East State Street.
Schulze, Carl A., M.D., 49 East Main Street.
Sigrist, Christopher W., M.D., 308 Collins Avenue.
Silbernagel, Charles Edward, M.D., 1033 North High Street.

CONNEAUT, Ashtebault County.
Cole, Geo. Harvey, 311 Main Street.

COVINGTON, Miami County.
Rosenberger, Abraham S., M.D.

DAYTON, Montgomery County.
Bittinger, Frank D., M.D., 23 West Fourth Street.
Laughlin, T. Livezery, M.D., 527 River Street.
Palmer, Harry E., 226 North Main Street.
McCann, T. Addison, M.D., 115 N. Perry Street.
Murphy, Frank Wellington, M.D., 38 So. Ludlow.
Webster, Frank, M.D., 700 Reibold Building.
Welliver, James Everson, 111 N. Jefferson.

DELAWARE, Delaware County.
Pulford, William Henry, M.D., 88 N. Sandusky Street.

DOYLESTON, Wayne County.
Stepfield, Alexander E., M.D.

ELYRIA, Lorain County.
Baldwin, Henry D., M.D.

FINDLAY, Hancock County.
Barnhill, Tobias G., M.D., 208 South Main Street.
Watson, Carl, M.D., 208 So. Main Street.

GALION, Crawford County.
Marsh, Guy C., M.D., 209 South Market Street.

GREENFIELD, Highland County.
Goldsmith, Alfred E., M.D.

HAMILTON, Butler County.
Goodman, Julia, M.D., 40 Ross Street.
Overpeck, James W., M.D., Third and Dayton Streets.
Schell, Samuel U., 110 N. Third Street.

HELENA, Sandusky County.
Crismore, John M., M.D.

HICKSVILLE, Defiance County.
Lanning, Willet Scott, M.D.

IRONTON, Lawrence County.
Justice, Harry Brick, M.D., 14 South Third Street.

JERRY CITY, Wood County.
Wollam, J. Frank, M.D.

LANCASTER, Fairfield County.
Hershberger, Joseph P., M.D., 351 East Main Street.
Junkerman, Charles F., 405 N. Broad.

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MANSFIELD, Richland County.
Ecki, Simon T., M.D., 365 Park Avenue W.
MARIETTA, Washington County.
Curtis, Harry N., M.D., 314 Second Street.
Curtis, Helen Endora, 314 Second Street.
McCleary, Jos. R., M.D., 24 Putnam Street.
MASSILLON, Stark County.
Dimon, Robert B., 70 E. Main.
MARION, Marion County.
Sawyer, Charles E., M.D.
MEDINA, Medina County.
Damon, G. J., M.D.
MIDDLETOWN, Butler County.
Reed, Thomas E., M.D.
MOUNT VERNON, Knox County.
Arndt, George O., M.D., 123 East High Street.
Conrad, Chas. K., 18 E. Vine Street.
De Camp, Frank Hurd, 410 William Street.
Eggelston, Eugene R., M.D., 100 North Main Street.
NELSONVILLE, Athens County.
Welch, Chas. F., M.D., 12 West Columbus Street.
NEWARK, Licking County.
Mitchell, John A., M.D., 69 Third Street.
NEW METAMORAS, Washington County.
Riley, C. T., M.D.
NEW PHILADELPHIA, Tuscarawas County.
Sigrist, Philip H., M.D., East High Street.
NILES, Trumbull County.
Claypool, John B., 156 Furnace Street.
Clingan, Thomas Omar, M.D., 22 Main Street.
Gaston, Sarah P., Main Street.
NORWALK, Huron County.
Simmons, S. E., M.D. 82 West Main Street.
OBERLIN, Lorain County.
Bissell, Fred C., 13 North Main Street.
Hawkins, Ellen F., M.D., 31 West College Street.
Pyle, Harold Ward, M.D., 5 West College Street.
OXFORD, Butler County.
Munns, Charles O., M.D.
PIQUA, Miami County.
Fahnestock, Joseph C., M.D.
PLYMOUTH, Richland County
Fackler, Joshua M., M.D.
PORTSMOUTH, Scioto County.
Gault Wm. Edward, M.D., 96 E. 2nd Street.
PROSPECT, Marion County.
Lunger, Justus S., M.D., East Water Street.
ROCK CREEK, Ashtabula County.
Morrison, Frank A., M.D., 6 South Main Street.

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OHIO

SALEM, Columbiana County.
Church, T. T., M.D., 31 Lincoln Avenue.
SANDUSKY, Erie County.
Gillard, Edwin, M.D., 423 Columbus Avenue.
Morley, Frank W., Washington Avenue.
SIDNEY, Shelby County.
Beebe, Henry E., M.D.
Ferree, Judson A., M.D.
Reddish, Albert W., M.D.
SOUTH EUCLID, Cuyahoga County.
Rowland, Justin E., M.D.
SOUTH CHARLESTON, Clark County.
Whittaker, Harry O., M.D.
SPRINGFIELD, Clark County.
Grant, George D., M.D., 16 W. High Street.
House, Robert B., M.D., 108 East High Street.
Miller, Harry T., 113 E. High Street.
ST. MARYS, Auglaize County.
Pintler, Hiram E., M.D.
Shuffleton, Frank A., 209 W. High Street.
STRUTHERS, Mahoning County.
Wallace, C. R., M.D.
TOLEDO, Lucas County.
Barnum, Arthur T., M.D., 2524 Collingwood Avenue.
Butman, Emma W., M.D., 1758 Erie Street.
Claypol, Albert, M.D., 2217 Fulton Street.
Hays, Emma L. Boise, M.D., 2236 Monroe Street.
Humphrey, William A., M.D., 2235 Maplewood Avenue.
Maxwell, Lewis K., M.D., 1615 22nd Street.
Rees, Owen, M.D., 314 Erie Street.
Watts, William, M. D., 339 Huron Street.
Zbinden, Christian, 431 Nebraska Avenue.
TROY, Miami County.
Means, J. W., M.D.
UNEAPOLIS, Auglaize County.
Hurlburt, John W., M.D., Ohio Street.
URICHSVILLE, Tuscorawas County .
Cash, Nathan, M.D., 69 Third Street.
XENIA, Greene County.
Hewell, W. S., O. S., and S. O. Home.
WARREN, Trumbull County.
Rolston, Rose Amenda, M.D., 52 High Street.
Sherwood, H. A., M.D.
WASHINGTON C. H., Fayette County.
Estep, Charles S., M.D.
Hodson, Geo. Stanton.
XENIA, Greene County.
Hewell, W. S., M.D., O. S. & S. O. Home.
YOUNGSTOWN, Mahoning County.
Blaine, William M., M.D.
Ginn, Arba S., 307-8 Federal Building.

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Hills, Howard Bakewell, M.D.
McGranaghan, William H., M.D., 220 Federal Street.
ZANESVILLE, Muskingum County.
Smith, Francis A., M.D., 18 South Fourth Street.

Oklahoma Territory.

WOODWARD.
Sawyer, Eugene W., M.D.

Oregon.

MCMINNVILLE.
McNeill, Alonzo L., M.D.
PORTLAND, Multnomah County.
Jefferds, Henry Clark, M.D., Dekum Building.
Miller, Byron E., M.D., "The Dekum."
Nichols, Annie S., M.D., "The Deckum."

Pennsylvania.

ALLEGHENY, Allegheny County.
Calhoun, John Charles, M.D., 803 Arch Street.
Nicholson, Harry Schuyler, 621 Arch Street.
Small, Stanley G., M.D., 152 Taggart Street.
Wallace, Homer Dawson, 214 Laycock Street.
White, Roland T., M.D., 914 Western Avenue.
Willard, Lewis Henry, M.D., 236 Western Avenue.
ALLENTOWN, Lehigh County.
Biltner, Albert Jacob, M.D., 1036 Hamilton Street.
Hassler, William A., M.D., 105 North Eighth Street.
Martin, Constantine H., M.D.
Slough, Frank J., M.D.
ALTOONA, Blair County.
Baker, Albert L., 1400 Twelfth Avenue.
Blackburn, Edwin C., 1421 Eleventh Avenue.
Morrow, Emory H., M.D., 943 Seventeenth Street.
BEAVER FALLS, Beaver County.
Moon, Seymour B., M.D., 1314 Eighth Avenue.
BELLVUE.
Cooper, Roy Cummings, Bank Building.
BETHLEHEM, Northampton County.
Garis, Frank A., M.D., 220 South Broad Street.
BLOOMINGTON, Columbia County.
Champlin, Henry William, M.D., 37 West Main Street.
BRADFORD, McKean County.
White, A. Grace, M.D., 87 Main Street.
BRISTOL, Bucks County.
Weaver, Willis P., M.D., 320 Radcliff Street.
BRYN MAWR, Montgomery County.
Powell, William C., M.D.

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PENNSYLVANIA

CATASAUQUA, Lehigh County.
Yoder, Daniel, M.D.
CHAMBERSBURG, Franklin County.
Bowman, Benjamin, M.D.
Crawford, Kathrine, M.D., 131 North Main Street.
CHESTER, Delaware County.
Crowther, Isaac, M.D. 100, Madison Street.
Hubbard, Charles H., M.D., 425 Broad Street.
Maddux, Daniel P., M.D., Eighth and Madison Streets.
Mercer, Robert P., M.D., 223 West Third Street.
Perkins, Charles W., M.D., 403 Broad Street.
Powell, Franklin, M.D., 241 East Fifth Street.
Webster, George C., M.D., 305 West Seventh Street.
COATESVILLE, Chester County.
Pratt, John W., M.D.
COLLEGEVILLE, Montgomery County.
Krusen, Edward A., M.D.
COLUMBIA, Lancaster County.
Taylor Wm. Gardiner, M.D., 216 Locust Street.
DEVON, Chester County.
Brown, William K., M.D., Box 82.
DU BOIS, Clearfield County.
Gann, George Willard, M.D.
EASTON, Northampton County.
Detwiller, John J., M.D.
Seibert, Walter W., M.D., 43 South Fourth Street.
Seibert, William A., M.D.
EDGE HILL, Montgomery County.
Godshall, Samuel G., M.D.
EMAUS, Lehigh County.
Slough, William C. J., M.D.
ERIE, Erie County.
Cranch, Edward, M.D., 109 West Ninth Street.
Gifford, Edward F., M.D., 221 West Eighth Street.
Phillips, Joseph R., 15 East Eighth Street.
FLEETWOOD, Berks County.
Lentz, Levi R., M.D.
FRANKLIN, Venango County.
Irwin, Thomas A., M.D., 1234 Liberty Street.
McBride, Lewis E., 78 Thirteenth Street.
GERMANTOWN, PA.
Leopold, Wm. C., M.D., 310 Crelton Avenue.
GLEN ROCK, York County.
Seitz, William Clinton, M.D.
GREENCASTLE, Franklin County.
Nowell, John F., M.D.
HANOVER, York County.
Everhart, Oliver T., M.D.
Fleagle, Maurice Monroe, M.D., 37 York Street.

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PENNSYLVANIA

HARRISBURG, Dauphin County.
Fager, Charles B., M.D., 120 Walnut Street.
Swartz, J. Ross, M.D., 236 North Third Street.
HATBORO, Montgomery County.
Reading, Thomas, M.D.
HOLLIDAYSBURG, Blair County.
Stitzel, Jonas Wakefield, M.D.
HONESDALE, Wayne County.
Peterson, Pierson B., M.D.
JEANNETTE, Westmoreland County.
Robinson, Clarence G., M.D.
JENKINGTON, Montgomery County.
Heritage, Alfred C., M.D.
JOHNSTOWN, Cambria County.
Kistler, Horace Edwin, M.D., 313 Main Street.
KANE, McKean County.
Heimbach, James M., M.D., 12 Greeves Street.
KENNETT SQUARE, Chester County.
Johnson, Isaac D., M.D.
LANCASTER, Lancaster County.
Snyder, Elwood S., M.D., 425 North Queen Street.
LANGHORN, Bucks County.
Heritage, Joseph B., M.D.
LEWISTOWN, Miffin County.
Griffith, John B., M.D.
LINESVILLE, Crawford County.
Collins, Allen Bennett, M.D.
MCKEESPORT, Allegheny County.
Burlingame, Frank W., M.D.
MEADVILLE, Crawford County.
Parsons, Edgar C., M.D.
MEDIA, Delaware County.
Pratt, Trimble, M.D.
MT. MORRIS, Greene County.
Bradford, George M., M.D.
NEW BRIGHTON, Beaver County.
Boyd, John S., M.D.
Pettit, Evelyn Sarah, M.D., 1109 Third Avenue.
NEW CASTLE, Lawrence County.
Sankey, B. E. M.D., 56 S. Jefferson Street.
NORRISTOWN, Montgomery County.
Shinn, Charles Tiel, M.D., 17 East Penn Street.
NORWOOD, Delaware County.
Baier, George F., M.D.
OAKMONT, Allegheny County.
Cooper, William Henry, M.D.
OIL CITY, Venango County.
Curran, Edwin J., M.D.
Sellew, Sylvester Wolcott, 17 Center Street.

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PHILADELPHIA, PENNSYLVANIA

PHILADELPHIA, Philadelphia County.

Adams, Theodore Lewis, M.D., 1831-33 Chestnut Street.
Allen, John V., M.D., 4637 Frankford Avenue.
Allen, Richard C., M.D., 4419 Frankford Avenue.
Arthur, Alexander Beck, M.D., 2039 Spring Garden Street.
Ashcraft, Leow Thomas, M.D., 833 Chestnut Street.
Baker, Daniel J., M.D., 1706 North Nineteenth Street.
Baker, Wm. Franklin, M.D., 2131 East Cumberland Street.
Bartlett, Clarence, M.D., 1506 Arch Street.
Belville, Jacob Edgar, M.D., 5915 Green Street.
Berens, Joseph, M.D., 1500 Green Street.
Betts, B. Frank, M.D., 1609 Girard Avenue.
Bibighouse, James Russell, 2156 Natrona Street.
Bigler, William H., M.D., 118 North Seventeenth Street.
Boericke, Felix A., M.D., 1011 Arch Street.
Boileau, John D., M.D., 804 Lehigh Avenue.
Bradford, Thomas L., M.D., 1862 Frankford Avenue.
Branson, Mary, M.D., 1719 Arch Street.
Brewer, Mary, M.D., 330 E. Chelten Avenue, Germantown.
Brown, Christian H., 1022 Walnut Street.
Brunner, Edgar P., M.D., 1108 Spring Garden Street.
Carmichael, Thomas H., M.D., 7127 Germantown Avenue, Germantown.
Carter, Woodward D., M.D., 1533 South Fifteenth Street.
Chase, Theodore Livingston, M.D., 1604 Walnut Street.
Christine, Gordon M., M.D., 2043 West Twelfth Street.
Closson, James H., M.D., 53 West Chelton Avenue, Germantown.
Claud, Charles Higginson, M.D., 1738 Franklin Street.
Cooke, Mary A., M.D., 2113 North Eighteenth Street.
Culin, William Davis, M.D., 855 North Forty-first Street.
Dudley, Pemberton, M.D., 1405 North Sixteenth Street.
Dudley, Perry Hall, M.D., 1405 North Sixteenth Street.
Ealer, Percy H., M.D., 815 North Twenty-fourth Street.
Fischer, J. A., M.D., 505 Green Street.
Furman, Horace S., M.D., 1705 Tioga Street.
Gilbert, Irwin B., M.D., 2027 Columbia Avenue.
Goodno, William C., M.D., 1733 Chestnut Street.
Gramm, Theodore J., M.D., 846 North Broad Street.
Griffith, Lewis B., M.D., 2449 Columbus Avenue.
Griffith, William M., M.D., 1827 North Seventeenth Street.
Gross, Francis O., M.D., 1506 North Seventh Street.
Guernsey, Joseph C., M.D., 1923 Chestnut Street.
Gumpert, Benjamin B., M.D., 840 Franklin Street.
Haines, Oliver Sloan, M.D., 137 North Fifteenth Street.
Hancock, Elmer E., M.D., 1443 North Seventeenth Street.
Hancock, Joseph, M.D., 1639 Columbia Avenue.
Hartley, Arthur, M.D., 2109 W. Susquehanna Avenue.
Hassler, J. Wyllis, M.D., 1503 Poplar Street.
Humphrey, Edward, M.D., Somerton.
James, Bushrod W., M.D., Corner Green and Eighteenth Streets.
James, D. Bushrod, M.D., 2005 North Twelfth Street.

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PHILADELPHIA, PENNSYLVANIA

James, John E., M.D., 1521 Arch Street.
Johnson, Maria N., M.D., 109 So. 20th Street.
Jones, John J., M.D., 1802 Mount Vernon Street.
Jordan, Oscar J., M.D., 704 Suydam Avenue.
Karsner, Charles W., M.D., 1320 South Broad Street.
Kase, Edmund Harris, M.D., 1325 Girard Avenue.
Knerr, Calvin B., M.D., 1831 Chestnut Street.
Knowlton, William Waldo, M.D., 113 South Sixteenth Street.
Korndoerfer, Augustus, Jr., M.D., 1728 Green Street.
Korndoerfer Augustus, M.D., 142 North Eighteenth Street.
Krewson, Amos D., M.D., 4613 Paul Street, Frankford.
Kurtz, Alfred J., M.D., 1520 South Broad Street.
Layman, Alfred, M.D., 1630 North Eighteenth Street.
Leopold, Herbert Preston, M.D., Germantown.
Lichtenwalner, Abbott B., M.D., 2435 North Seventh Street.
Macfarlan, Duncan, M.D., 3924 Chestnut Street.
Macfarlan, Malcolm, M.D., 1805 Chestnut Street.
Mackenzie, George W., M.D., Somerton.
McClure, Eliza Lang, M.D., 1919 Wallace Street.
Mansfield, Harry Knox, M.D., 19 West Chelton Ave., Germantown.
Mansfield, Job R., M.D., 4852 Main Street, Germantown.
Marshall, Anna M., M.D., 1420 Chestnut Street.
Martin, Robert Wilkie, M.D., 1831 Chestnut Street.
Mercer, Edward W., M.D., 1705 Arch Street.
Middleton, Caleb S., M.D., 1523 Girard Avenue.
Mitchell, John Nicholas, M.D., 1505 Spruce Street.
Mohr, Charles, M.D., 1823 Green Street.
Mukurjee, A. N., Children's Homœopathic Hospital.
Myers, Charles E., M.D., 170 Green Lane, Manayunk.
Norton, Claude R., M.D., 700 North Fortieth Street.
Plincher, Wm. Allen, 5915 Walker Street.
Palen, Gilbert Joseph, M.D., Germantown.
Paxon, Oliver H., M.D., 1733 Arch Street.
Pettengill, Eliza F., M.D., 300 North Tenth Street.
Posey, Louis Plumer, M.D., 1435 Walnut Street.
Raue, C. Sigmund, M.D., 121 North Tenth Street.
Reading, J. Herbert, M.D., 1811 Green Street.
Reeves, Joseph M., M.D., 1525 Spruce Street.
Ridge, Jonathan T., M.D., 1617 North Seventh Street.
Ridgway, Mary Davis, M.D., 5336 Wayne Avenue.
Russell, Antoinette E. C., M.D., 5348 Wayne Avenue, Germantown.
Sartain, Harriet J., M.D., 212 West Logan Square.
Schriener, Emma T., M.D., 190 Maplewood Avenue.
Schwenk, Clayton S., M.D., 1319 Jefferson Street.
Shallcross, Isaac G., M.D., 1617 Arch Street.
Shellenberg, Charles Neil, M.D., 1831 Wallace Street.
Shoemaker, Daniel Webster, M.D., 1924 Green Street.
Smilie, Nathan, M.D., 1524 Chestnut Street.
Snader, Edward R., M.D., 1919 Arch Street.
Spencer, William, M.D., 1820 Chestnut Street.

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Stewart, George W., M.D., 1728 Chestnut Street.
Stork, James C., M.D., 4700 Chester Avenue.
Thomas, Charles M., M.D., 1623 Arch Street.
Thompson, Landreth W., M.D., 1701 Green Street.
Tomlin, Richard Elmer, M.D., 207 North Eighth Street.
Tuller, John J., M.D., 1931 Chestnut Street.
Van Baun, William W., M.D., 1402 Spruce Street.
Van Deusen, Edwin H., M.D., 2105 Tioga Street.
Van Gunten, Fred W., M.D., 1432 Diamond Street.
Van Lennep, Gustave Adolphe, M.D., 1421 Spruce Street.
Van Lennep, William B., M.D., 1421 Spruce Street.
Wait, Oliver B., M.D., 1230 South Fifty-seventh Street.
Ward, John McE., M.D., 1915 Susquehanna Avenue.
Waylan, Julia Gould, M.D., 1832 Tioga Street.
Weaver, Chandler, M.D., Fox Chase P. O.
Weaver, Harry Sands, M.D., 1621 Chestnut Street.
Williamson, Matthew S., M.D., 1311 Arch Street.
Wurtz, Charles B., 2413 N. Fifth Street.
Yale, Arthur Wells, M.D., 1901 Park Avenue.
Zeigenfus, A. Frank, M.D., 1124 Wallace Street.

PITTSBURG, Allegheny County.

Bier, Peter A., M.D., 4200 Butler Street.
Bingaman, C. F., M.D., 922 Penn Avenue.
Blair, William Wightman, M.D., 406 Penn Avenue.
Chapman, Millie J., M.D., 321 Smith Block, Sixth Street.
Cook, W. Casper, 501 Bijou Building.
Edmundson, Walter F., M.D., 1321 Fifth Avenue.
Elliott, John D., M.D., Homœopathic Hospital.
Fulton, Henry W., M.D., corner Ripley and Highland Avenue.
French, Malachi R., M.D., 627 Smithfield Street.
Gregg, Edw. R., M.D., 334 So. Highland Avenue.
Herron, Charles D., M.D., 3505 Butler Street.
Hofmann, Charles H., M.D., 510 South Highland Avenue.
Johnson, Anna, 5115 Liberty Avenue.
Marshall, Robert S., M.D., 424 Shady Avenue.
Martin, W. J., M.D., 1712 Carson Street, S.S.
McClelland, James H., M.D., Fifth and Wilkins Avenue.
McClelland, John B., M.D., 409 Penn Avenue.
McClelland, Robert Watson, M.D., Fifth and Wilkins Avenues.
Miller, Zachary T., M.D., 2013 Carson Street.
Mueller, Gustave A., M.D., 400 Penn Avenue.
Rankin, John S., M.D., cor. Roup and Howe Avenues.
Sawers, Frank C., 5208 Second Avenue.
Seip, C. P., M.D., 636 Penn Avenue.
Thompson, James Henry, M.D., 515 Penn Avenue.

PITTSTON, Luzerne County.

Johnson, Theodore M., M.D., 200 Susquehanna Avenue.

PLYMOUTH, Luzerne County.

Saudel, John H., M.D.

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PENNSYLVANIA

POTTSTOWN, Montgomery County.
Rossiter, Edwin B., M.D., 34 High Street.
Shute, Albert Clement, M.D., 421 High Street.
POTTSVILLE, Schuylkill County.
Boyer, Francis W., M.D.
READING, Berks County.
Kline, David C., M.D.
Rittenhouse, Jacob S., M.D., 38 South Fourth Street.
Schantz, M. Margaret Hassler, M.D., 402 North Fifth Street.
Schollenberger, Lewis A., M.D., 637 Walnut Street.
RENOVO, Clinton County.
Heimbach, Allen Eugene, M.D., 125 Sixth Street.
ROCHESTER, Beaver County.
McCauley, John C., M.D., 320 Connecticut Street.
SCRANTON, Lackawanna County.
Brewster, Frederick D., M.D., 109 Jefferson Street.
Coolidge, John W., M.D., 334 Washington Street.
Heilner, Herbert Franklin, M.D., Burr Building.
Peck, John Lyman, M.D., 322 Washington Street.
Pursell, James Perry, M.D., 409 Cornell Building.
Roberts, Charles W., M.D., 638 Washington Avenue.
Ware, Horace B., M.D.
SHARPSBURG, Allegheny County.
Dinsmore, Samuel W. S., M.D.
SHARON, Mercer County.
Walker, Hannah Ellen M.D., 24 Shenango Street.
SHIPPENSBURG, Cumberland County.
Brown, Samuel G. A., M.D., Lock Box 99.
SPRINGBORO, Crawford County.
Parsons, Anson, M.D.
SUSQUEHANNA, Susquehanna County.
Simmons, Silas S., M.D.
TITUSVILLE, Crawford County.
Burchfield, Samuel Newton, 39 E. Main Street.
Sager, Cyril Wichfield, M.D., 108 West Main Street.
UNION CITY, Erie County.
Stem, Henry L., M.D.
UNIONTOWN, Fayette County.
Bowie, Alonzo P., M.D., 87 Main Street.
WARREN, Warren County.
Davies, J. Norman, 209 Third Street.
WALTER'S PARK, Berks County.
Walter, Robert, M.D.
WASHINGTON, Washington County.
Maurer, Joseph M., M.D., 59 West Wheeling Street.
WAYNE, Delaware County.
Smedley, Charles Davis, M.D.
WEST ALLEGHENY, Penn.
Goff, Ella D., M.D., 10 No. Diamond Street.

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WAYNESBURG, Greene County.
Blair, Thos. L., M.D.
WEST PHILADELPHIA.
Sloan, Malachi Wilson, M.D., 4830 Balto Avenue.
WILKESBARRE, Luzerne County.
Bullard, J. Arthur, M.D.
WILKINSBURG, Allegheny Cuonty.
Varner, Anna Devinn, M.D., 613 Wood Street.
WILLIAMSPORT, Lycoming County.
Reinhold, Hannah C., M.D., 761 West Fourth Street.
YORK, York County.
Crawford, Katherine M., M.D., 204 E. Market Street.
Dehoff, John W., M.D., 453 West Market Street.

Rhode Island.

BLOCK ISLAND, Newport County.
Champlin, John Carder, M.D.
BRISTOL, Bristol County.
Gooding, Gertrude, M.D.
Hasbrouck, Cornelius J., M.D., Hope Street.
CENTERDALE, Providence County.
Barnard, Charles A., M.D.
EAST PROVIDENCE, Providence County.
Allison, George Freeman, M.D., Warren Avenue.
NEWPORT, Newport County.
Chance, Nathaniel Ray, M.D., 89 Touro Street.
OLNEYVILLE, Providence County.
Lippitt, Louis Davis, M.D., 41 Pocasset Avenue.
PAWTUCKET, Providence County.
Bennett, John Hillman, M.D., 306 High Street.
PROVIDENCE, Providence County.
Arnold, Oliver Henry, 275 Washington Street.
Brown, Asa W., M.D., 27 Burnett Street.
Brown, Lucy H. A., M.D., 420 Westminster Street.
Budlong, John Clark, M.D., 604 Westminster Street.
Budlong, Martin S., M.D., 604 Westminster Street.
Crocker, Harry Clinton, M.D., 67 Common Street.
Green, Charles L., M.D., 16 Jackson Street.
Hall, Robert, M.D., 60 Cranston Street.
Hasbrouck, Sayer, M.D., 105 Broad Street.
Hunt, Annie W., M.D., 217 Washington Street.
Lance, John D., M.D., 21 Broadway.
Kenyon, Frances Aureola, M.D., 865 North Main Street.
Moss, Mary Denison, M.D., 231 Broadway.
Peck, George Bacheler, M.D., 865 North Main Street.
Sanger, Henry Mortimer, M.D., 1040 Westminster Street.
Sawin, Isaac W., M.D., 582 Broadway.
Shipman, Thomas Harris, M.D., 281 Benefit Street.

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Stone, Waldo H., M.D., 133 Orms Street.
Whitmarsh, Henry Allen, M.D., 62 Jackson Street.
WESTERLY, Washington County.
Pagan, Frank C., M.D.
Webster, Samuel C., M.D., 99 High Street.
WOONSOCKET, Providence County.
Kingsbury, Edward N., M.D., 93 Blackstone Street.

South Dakota.

ABERDEEN, Brown County.
Fowler, DeWitt C., M.D.
DEADWOOD, Lawrence County.
Wedelstaedt, Von, George Sparr.
SOUTH SIOUX FALLS, Minnehaha County.
Fulford, George Howard, M.D., 233 Philips Avenue.
VERMILLION, Clay County.
Cotton, Alonzo A., M.D.

Tennessee.

CHATTANOOGA, Hamilton County.
Price, Emmor H., M.D., 400 Georgia Avenue.
HARRIMAN.
Rockwell, John A., M.D., Box 104.
NASHVILLE, Davidson County.
Dake, Walter M., M.D., 218 North Vine Street.
Dake, William C., M.D., 218 North Vine Street.
McGavock, Clara Plimpton, M.D.

Texas.

DALLAS.
Thatcher, William F., M.D., 411 Linz Building.
West, Isaac C., M.D., 350 Elm Street.
DENISON, Grayson County.
Warren, H. Anna, M.D., 817 Bond Street.
FORT WORTH Tarrant County.
Pollock, Joseph Robert, M.D.
GAINESVILLE, Cooke County.
Stiles, Hunter Bell, M.D., Grand Avenue.
GALVESTON, Galveston County.
Mercer, William M., M.D., 1815 Church Street.
SAN ANTONIO, Bexar County.
Bliem, Milton J., M.D., 425 Navarro Street.
Wilson, Chas. A., 313 Houston Street.
Watts, Edith Gertrude, M.D., Hicks Building.
TEXARKANA, Texas County.
Williams, Perry C., M.D.

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VERNON, Wilbarger County.
Blackman, George Edwin, M.D.
WACO, McLellan CoCunty.
Streeter, Geo. Dallas, M.D., 216 N. 5th Sttreet.

Utah.

OGDEN, Weber County.
Wherry, Curtis A., M.D.
SALT LAKE CITY, Salt Lake County.
White, John T., M.D., 28 State Street.

Vermont.

BELLOWS FALLS, Windham County.
Kirkland, Edward, M.D.
BURLINGTON, Chittenden County.
Colvin, Harvey E., M.D. 150 Cherry Street.
Sparhawk, George E. E., M.D.
MANCHESTER CENTRE, Bennington County.
Wymond, Edmond L., M.D.
MIDDLEBURY, Addison County.
Harter, Frank Dexter, M.D.
Noble, Daniel Cook, M.D.
NEWPORT, Orleans County.
Whitacre, Eugene E., M.D.
ROCHESTER, Windsor County.
Richardson, E. B., M.D.
RUTLAND, Rutland County.
Gale, Charles A., M.D.

Virginia.

DANVILLE, Pittsylvania County.
Koens, Harry E., M.D., 647 Main Street.
HOT SPRINGS, Bath County.
Williams, Eli Cone, M.D., The "Homestead."
NEWPORT NEWS, Warwick County.
Jackson, Noah, M.D., 125 Twenty-eighth Street.
NORFOLK, Norfolk County.
Webster, Frank P., M.D., 316 Freemason Street.
RICHMOND, Henrico County.
Bagby, George Franklin, M.D., 206 East Grace Street.
Baker, Harry Burgwyn, M.D., 1 East Grace Street.
Taber, George A., M.D., 105 West Grace Street.
SUFFOLK, Nansemond County.
Skiles, Francis W., M.D.

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Washington.

SEATTLE, King County.
Churchill, Frederick A., M.D., 524 Burke Building.
Hastings, Wm. C., M.D., Dorrn's Block.
Young, E. Weldon, M.D., 1023 Columbia Street.
SPOKANE, Spokane County.
Chandler, Jean Christie, M.D., 402 Traders Building.
Grove, Charles E., M.D., Hyde Block.
Olmstead, Elmer D., M.D.
WALLA WALLA, Walla Walla County.
Russell, Walter E., M.D., 25 E. Main Street.

West Virginia.

CHARLESTON, Kanawha County.
Lounsbery, George, M.D., 562 Quarrier Street.
MORGANTOWN, Monongalia County.
Casselberry, Melvin L., M.D.
PARKERSBURG, Wood County.
Muhleman, Charles, M.D., 611 Market Street.
SISTERSVILLE, Tyler County.
Wells, George S., M.D.
WELLSBURG, Brooke County.
Roberts, Arthur Augustine, M.D.
WHEELING, Ohio County.
Fawcett, John M., M.D., 1116 Market Street.
Morris, Wm. Turner, 1407 Chapline Street.
Morris, John W.

Wisconsin.

APPLETON, Outagamie County.
Kanouse, Abijah W., M.D.
BEAVER DAM, Dodge County.
Webb, William B., M.D.
BELOIT, Rock County.
Van Delinder, Effie M., M.D., 556 Public Avenue.
BLACK RIVER FALLS, Jackson County.
Abbott, Edward C., M.D., Main Street.
COLUMBUS, Columbia County.
Peck, Harry G., M.D.
EDGERTON.
Martin, Frederick H.
ELKHORN, Walworth County.
Austin, Edson C., M.D.
GREEN BAY, Brown County.
Olmstead, Austin Frederick, M.D.
KENOSHA, Kenosha County.
Erwin, William, M.D.
Pennoyer, Nelso A., M.D.

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WISCONSIN

Ripley, George H., M.D.

LANCASTER, Grant County.

Hassell, Samuel E., M.D.

MADISON, Dane County.

Everett Edw., 5 E. Main.

Brown, Eugene A., M.D., 121 East Washington Avenue.

MANITOWOC, Manitowoc County.

Paine, Richard K., M.D.

MILWAUKEE, Milwaukee County.

Barndt, Milton A., Grand Avenue and Third Street.

Beebe, Eugene W., M.D., 173 Wisconsin Street.

Carlson, Oscar W., M.D., 425 Milwaukee Street.

Forsbeck, Filip A., M.D., 121 Wisconsin Street.

Irving, Walter W., M.D., 121 Wisconsin Street.

Johnson, Solomon D., M.D., 204 Grand Avenue.

Lewis, Joseph, M.D., 330 National Avenue.

Sherman, Lewis, M.D., 171 Wisconsin Street.

RACINE, Racine County.

Davis, John J., M.D., 504 Monument Square.

SHARON, Walworth County.

Treat, Charles R., Jr., M.D.

VIROQUA, Vernon County.

Suttle, Henry J., M.D.

WEST LIMA, Richland County.

Cole, Beder A., M.D.

WEST SUPERIOR, Douglas County.

Russell, Henry A., M.D., 1705 Broadway, W. S.

WHITEWATER, Walworth County.

Leland, Aaron G., M.D.

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REPORT

OF THE

NECROLOGIST

A. C. COWPERTHWAITE, M. D.

NECROLOGIST

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In Memoriam

1902

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ALONZO BOOTHBY
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CLIFTON FRENCH HAYES
GUSTAVUS E. GRAMM
JOHN R. HAYNES
WILLIAM TOD HELMUTH
HENRY CLARK HOUGHTON
ELIAS C. PRICE
SELDEN HAINES TALCOTT

HONORARY MEMBER

RICHARD HUGHES

ASSOCIATE HONORARY MEMBER

EMILY FAIRBANKS TALBOT

JUNIORS

SARAH W. ANDREWS
CHARLES L. BONNELL
WILLIAM C. COUDEN
FINDLEY EDGAR DOWNEY
JAMES C. DUNCAN
EDWARD A. FISHER
JOHN A. GANN
JULIA GOODMAN
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JOHN C. KIRKPATRICK
CHARLES ELLIOTT PINKHAM
HUDSON J. PULVER
FRANCIS R. SCHMUCKER
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ALONZO L. TALMAGE
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HELMUTH—TALCOTT

Look at my hair, and see it silver gray;
  Look at my eyes, behold the dangling glasses;
Look at my ears; you know full well that they
  Are not acute to every sound that passes.

You knew me when these same old locks were brown,
  With ears responsive and eyes quick to see;
I recollect when you came up to town
  With letters introductory to me.

A stripling then from dear old Munger's care,
  Burning with the Æsculapian flame,
With slender body and with flowing hair,
  Up to your Alma Mater's courts you came.

Do you remember, then, that I was teaching
  The new suspension for a fractured thigh?
The old straight splint of Physic was impeaching
  When you besought me Munger's splint to try.

Take down the worn old volume from the shelves,
  Turn you to page five hundred ninety-five;
Ah! mem'ry then will tell us of ourselves,
  Both you and I—Thank God we are alive!

As retrospection stealeth o'er the years
  To touch the men who lectured then to you,
Our hearts grow sad—our eyes o'erflow with tears,
  So many gone—the remnant still so few.

But I must play you Ganymede to-night,
  And give this cup, all filled with ruby wine,
In friendship's name from those who, with delight,
  Have watched your progress since you fell in line.

Take it, old man, with all the love it offers;
  Take it and keep it, for it tells a story;
Take it—'tis better than o'erflowing coffers;
  Take it, resplendent with true friendship's glory.

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Wm Tod Helmuth

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NOTICES OF DECEASED MEMBERS

WILLIAM TOD HELMUTH, A.M., M.D., LL.D

NEW YORK.

Wm. Tod Helmuth was elected a member of the Institute at its tenth session, held at Cleveland, Ohio, in 1853. He was made Provisional Secretary in 1865; elected President of the Institute in 1867; appointed a member of the Hahnemann Monument Committee in 1892 to 1900; gave an "Ode to Hahnemann" at the dedication exercises at the unveiling of the monument at Washington, D. C., in 1900.

Before the dawning of the morning of the fifteenth day of May, nineteen hundred and two there fell out of the ranks of the devotees to homœopathy one of its most esteemed noblemen, William Tod Helmuth, A. M., M. D., LL. D., at the ripe age of the three score and ten limit, of which he lacked only a few months. With the declining day, so the decline of that life, and as shadow deepened into darkness and the night wore apace, so faded that glimmering life, and as it bordered upon the approaching of another day that spirit awoke in the dawn of a new light in the mansion of its last habitation.

When great men die it has become trite to remark that their work was not finished, a remark that will as oft bear analysis. We can hardly regard it as true when we review the lives of a few of the representative men of the homœopathic faith, the German Hahnemann, the English Hughes, the Americans Talbot and Helmuth. Certainly from our point of view, they had reached their zenith.

It seems indeed true, that they had fought the good fight, they had finished their course, they had kept the faith, and that henceforth there is laid up for them a crown of glory.

Such conspicuous figures scarce need to have rehearsed the circumstances of their birth, their parentage or ancestry, however illustrious it may have been, to add to their fame.

The merits of their lives are sufficiently emblazoned as to require little comment, for their works do follow them. It is more a matter of habit, perhaps, that we speak at all, or as a matter of record for influence upon those who come after us who had not the rare privilege of a contemporaneous life. To rehearse the life and works of the subject of our sketch would be but reiteration of what has many times appeared in the transactions of this and kindred societies and schools, so many of which he was an active or honorary member, not only in this but in European countries as well.

No one school, no one college, no one city, state or country can lay claim to the education of this internationally respected humanitarian. His mental horizon was bounded by a circumference beyond the limits of the "window of

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the soul." He learned from everything and absorbed only as the most receptive and intellectual can. Suffice it to say that William Tod Helmuth was born in the American Quaker city in 1833. His literary course was taken at Timothy's College, Baltimore, and the medical at the Homœopathic College of Pennsylvania, from which he graduated in 1853. He subsequently studied in the hospitals of Europe, occupied the chair of Professor of Anatomy at his alma mater, was Professor of Surgery and Dean of St. Louis College of Homœopathic Physicians and Surgeons in 1858, which college he had been instrumental in establishing; was also Dean and Professor of Surgery in the New York Homœopathic Medical College and Hospital in 1870, and Chief Surgeon of the hospital staff, which positions he held at the time of his death. He occupied positions at the head of medical societies, and on important committees the highest in the pewer of his confreres to bestow, among them President of the American Institute of Homœopathy in 1867.

His medico-surgical works, known as "Helmuth's System of Surgery," with other literary writings, distinguished him as an author of some significance. He received the degree of LL. D. from Yale University in 1888.

In his broad sympathies, liberally cultivated tastes, varied activities and interests for humanity, he acquired a popularity which kept him constantly in demand to preside at meetings where it brought him ever in touch with his colleagues and the public. He was tendered many honors from citizens and professional societies which were accepted with the same modesty that always marked his distinguished career.

It is significant that a noted social function at which he was to have been present was being held in the city of his home at the time he was passing away. When the presentation words which had been prepared by this gifted writer were being read at the banquet, their author was suffering the throes of death. The sentiments of a poem of Dr. Helmuth's, read upon this occasion, were in accord with thoughts evidently affected by his approaching dissolution, and it probably is the last written expression of this illustrious man. With his departure, a magnificent creation of the image of his Master passed from life mortal to life immortal, and in its passage left a vacancy that can never be filled. For each life is an individuality, and such as this leaves an enduring memory, that of the pioneer in the surgery of the homœopathic school, the alert and professional man of letters and of art, the master mind and the skilled artist in his profession. He was the grand pioneer in this art—the man who dared stand forth and show the medical world that homœopathic physicians could be equally good surgeons with those of the dominant school. With courage undaunted and fortitude unequaled, he pushed forth into the fields heretofore untraversed by men who shared his faith in the practice of medicine according to the law of similia, and strange as it may seem, somewhat against the wishes and belief of his honored colleagues, who were so arduous and credulous as to think surgery was not needed if similibus was heeded. But, fraught with the courage of his convictions, he pressed on. And a man of so genial and congenial nature, so affable, so approachable, so reasonable and so gentlemanly, none could be offended with him, but were constrained to aid him, and soon found him and his surgical art to be a contingent that they could not well succeed without. The profession soon learned that a surgeon was a necessity to the life of the homœopathic school of medicine, and that in William Tod Helmuth they had a peer of any in the profession of

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other schools. His unique combination of therapeutic medicine and surgery, as illustrated in his works on surgery, are adequate expression in themselves of his broad and comprehensive views, and such literature established beyond dispute his loyalty to the illustrious truths of the honored father of homœopathy, and taught the followers of the law of similia that surgery had a place in our school—proving that even Hahnemann himself, by a simple illustration in his Organon, was a believer in the mechanical art of surgery. This most illustrous surgeon, this most illustrious homœopath, this most illumined man of letters and art, whom to meet but once was to know forever, to hear but once was to hear forever, whom to see but once was to remember forever, whom to know at all was to love, cherish and revere always, has laid down his rod and staff. But they shall comfort us. He has given us of his intellect and energy bountifully. Lovingly, gracefully, forcefully were his efforts ever put forth. Willingly, not grudgingly, has he given of his life labors for the upbuilding of the profession nearest and dearest to himself and to the benefit of others. Were I an artist in sculpture or painting, I feel I could mold or draw every feature and expression of that illumined face—so impressive was he. True to the life given to an object, he has endured the anxieties and the mental and physical strain that must inevitably accompany it, and he fell a victim to a disease of that vital organ that cannot endure without murmuring. But 'twas not a broken heart, for few men have enjoyed greater confidence of their fellow-men and colleagues, or languished less for earnest support and encouragement, and we may safely say that none, even the father of homœopathy himself, ever received a larger share of love and esteem than he whose loss we now are forced to feel. But words can but inadequately express the depths of grief or the greatness of the influence of this dead man—we say dead, but know what we mean, for he is not dead, nor even sleepeth, for his works do follow him, and after the passing of the sorrow, he lives again, honored, esteemed, lauded; nay, almost worshiped by the loyal homœopathic physician, for he was the American Hahnemann, carrying into surgery and uniting the healing power of *similia similibus curantur*, a point for the modern surgeon to notice and heed.

He needs no cold marble bust to mark the spot of his demise, for such an animated soul can never die. It lives in all our hearts and minds, and his works of greatness in literature and surgical art are recorded and preserved in the archives of the library and museum. His success, in part at least, must have been due to his loyalty, energy, progressiveness, and to his readiness to grasp the new, while holding fast to that which was good. To him life was real and earnest, and the grave is not his goal.

With his departure there went out of the Homœopathic School of Surgery, easily, its brightest light; but the rays of that ever-burning taper have, for an approaching half-century, so shed their light before and penetrated the minds of men that, seeing his good works, they have followed him and many have become famous in this branch of the profession.

To Dr. Helmuth more than to any one man do we owe the honor that today graces the surgery of our school. We must leave him in the flesh, but in the spirit let us emulate him and consecrate anew our lives to the fulfilment of a mutual obligation—to carry forward the work which he furthered. If we would show our appreciation of his labors, can we do better than keep the faith?

FRANK L. NEWTON.

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SELDEN HAINES TALCOTT, A.M., M.D., PH D.

BORN JULY 7, 1842, AT ROME, N. Y.

ENTERED INTO REST JUNE 15, 1902, MIDDLETOWN, N. Y.

In the death of Dr. Talcott the homœopathic profession loses one of its strongest advocates, inasmuch as he was one of the first to fully demonstrate the successful application of homœopathy in the treatment of the insane.

Nature had endowed him abundantly with her gifts, and he used them wisely, as shown by his record, beginning in the old academy at Rome, N. Y., and in his service in the Fifteenth Regiment of the New York Volunteer Engineers during the Civil War; in Hamilton College, where he graduated in 1869, and in the New York Homœopathic Medical College and Hospital, from which he graduated in 1872; in his practice in Waterville, N. Y., where he was associated with Dr. E. A. Munger, whose daughter, Sarah A. Munger, he married; and at Ward's Island Homœopathic Hospital, New York City, where he served as chief of staff from early in 1875 until April 24, 1877, when he resigned in order to take up his work as superintendent of the Middletown Asylum, now known as the Middletown State Homœopathic Hospital.

From his entrance into prominent official professional life he has attracted the attention of those who were opposed to him, as well as the admiration of his friends, by his ability, industry and tact, and by the successful manner in which, at all times and in all places, he has shown his unwavering adherence to the principles of old-fashioned homœopathy. Upon assuming the duties of medical superintendent at Middletown, he at once began the work of placing the institution on a sound financial basis, watching all expenditures closely, to see that they did not at any time exceed the income derived by the hospital.

He believed that, as it was a State institution, all classes of taxpayers should be freely received, and that to each and every patient should be given that degree of care and attention individually demanded by his social, physical and mental needs. The good of the patient was to be considered at all times, irrespective of the cost that this needed care and attention might involve. This he demonstrated was practicable, and it is a tribute to his executive genius that the Middletown Hospital won a name that is second to none other of its class in the world.

Untrammeled by previous experience with the insane, at a period in which old-time methods of labor, detention, seclusion and chemical and mechanical restraints were in vogue, his generous and philanthropic mind turned naturally to the study of hospital methods for the care and relief of the insane, with results that hitherto no superintendent in this country had ever attained.

Sympathetic kindliness, unceasing watchfulness, homœopathic and consequently humane treatment, became the ruling essentials, and the employment of hospital methods gradually crystallized into the "Hospital Idea," which meant the best care obtainable for the sick insane. To quote the doctor's own words, "We have always endeavored to practice the precepts of the Golden Rule in behalf of our patients. We have given them the benefits of the rest-treatment, which is simply obedience to that injunction of the Healer of Gennesaret, 'Come unto me all ye that labor and are heavy laden, and I will give you rest.' We have always believed that an exhausted physical system

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Faithfully Yours
Selden H. Talcott

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must be recuperated and thoroughly nourished before the nervous system can take on that tone and temper which makes it the fit residence of a sane and natural mind."

Conscientious attention and homœopathic treatment, with kindness ever uppermost, soon brought the Middletown Hospital marked approbation from the critical public, and the reports issued yearly by Dr. Talcott have been models in their way—full of interest to the profession and of high literary excellence. As one prominent alienist of the old school said to me, "The reports of the Middletown Hospital are the only ones I save. They are of value, and I frequently refer to them."

Dr. Talcott's work made the Middletown Hospital favorably known throughout Europe, as well as this country, one of the best reviews of the year's work done in Middletown coming from Belgium. When he first went to Middletown there were about one hundred patients; now there are nearly thirteen hundred; and the admissions during the hospital's life aggregate six thousand and over.

Just one month ago, on the evening of the dinner given to Dr. Talcott, commemorating his twenty-fifth anniversary at Middletown, Dr. William Tod Helmuth, who had prepared a poem for the occasion, and who was to have been the last speaker, passed away at his home just as the banquet closed.

Dr. Helmuth's verses, as read by Dr. George W. Robertson on the evening of the presentation of the cup, will be found on a preceding page.

What the profession has lost, what the public has lost, and what his wife has lost is beyond ordinary expression. Our sympathy goes out to them.

Ever helpful to others, he received recognition from his college, it having conferred upon him the degree of A. M. in 1872 and Ph. D. in 1882. He has been president of national, state and county homœopathic organizations. As a public speaker he had few equals, as a writer he was one of the best in our school. He has contributed only one volume to our medical literature, that on "Mental Diseases and Their Modern Treatment;" but he has written freely upon subjects connected with his work, and these articles have been printed in many of our journals and society transactions.

As professor of mental diseases, many old students of Hahnemann, and, later, those of the New York Homœopathic Medical College and Hospital, will remember their versatile teacher with pleasure. That kindness, sympathy and helpfulness he so willingly gave out to others will be remembered by thousands who came within the radius of his forceful personality. As Secretary Hay said of McKinley, so can we of Talcott:

"History is inexorable. She takes no account of sentiment and intention; and in her cold and luminous eyes that side is right which fights in harmony with the stars in their courses. The men are right through whose efforts and struggles the world is helped onward, and humanity moves to a higher level and a brighter day."

C. Spencer Kinney.

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RICHARD HUGHES, M. D., M. R. C. S., L. R. C. P.

ENGLAND.

Sudden as an electric shock or a thunderbolt from a summer sky, the news fell upon the scientific world, and a world of suffering humanity, that Dr. Richard Hughes was dead! In the midst of his life-work, in apparent perfect health, and with the joy of living and doing good glowing in his cheeks and his clear eyes, he was stricken. Alone and unaided, he went forth into the New Life. Alone, because on that journey we may take no companion; unaided, because the most brilliant physician in the world has found no remedy for that swift messenger that grasps the very center of life and stops irrevocably the current whose ebb and flow bear the secret mystery of being from birth to the last pale portal—death. It might be said that it was given to him to prove his belief that there is no such thing as death, for in a tiny space he stepped from the narrow portal of this life into the wonderful Beyond, where there is no sorrow to assuage, no pain for which to find a gracious cure.

Dr. Hughes was in every phase a man to love and honor. His plan of life was spread before him when many others have scarce laid aside the amusements of their boyhood. From the beginning of his career unto the end he followed a certain aim, and no sidetrack, however tempting, could lure him to diverge. And this not because he was marked as a dry savant, but because he chose to keep in the line unswervingly. His personality was extremely winning; his voice rich, clear and steady; his eyes beautiful in youth with the merry twinkle of fun or the soft glow of sympathy as occasion required, and always pure and true. He was tall and rather slender in figure, and as age drew on he leaned forward slightly, not as with years, however, but as though his tender ministrations to human sufferers had drawn him down to listen to their many and oft-times wearisome plaints, or as if the toil of the scholar had set its well-known seal upon him.

I knew him and had the pleasure of being closely associated with him during the organization of the International Congress of Homœopathic Physicians in Philadelphia during our Centennial celebration. He was my guest at that time and I learned to know him well, for his was a character not hard to study. He was handsome, with no shade of vanity; genial and gleefully able to either give or take a joke, without a gleam of undue levity. The well-spring of his life was pure as crystal, and as I gaze at his picture today I see only the development of his youthful traits in the still beautiful, searching eyes, the benignity of the forehead from which the dark locks have receded; the sweet, gentle expression of the face, ready to smile or to sympathize as friend or patient stood before him. In my hand is the journal bearing as its first article one from the pen of this great and good man, and a few leaves farther on a black bordered page telling of his sudden departure to the Better Land. Mist gathers in my eyes as I think that such men must pass from the earth and leave voids that none others can entirely fill. As a friend he was most lovable, as a physician most faithful, as a scientist and a writer he had not many peers, and few, if any, superiors. He advanced his ideas with force, yet showed graceful respect to those who disagreed with his views; and his knowledge, gained by the utmost concentration and research, has been ac-

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JOHN R. HAYNES
EDWARD A. FISHER
GUSTAVUS E. GRAMM

RICHARD HUGHES
JOHN C. BURGHER

HAYES CLIFTON FRENCH
EDGAR ADAMS WILSON
FRANCIS R. SCHMUCKER

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cepted as correct even by those who combated some of his theories. And he had attained the position of a great leader and teacher in homœopathy almost unconsciously, because his aim was not self-elevation, but the promulgation of the truth in medical science. So, also, he became a true benefactor to humanity and a beloved friend, never to be forgotten.

Alone they stand, those grand, brave lives that bear
  A touch of godliness, an aim so high,
That those who fain would know them must look up
  To make their progress as the years go by.

Yet e'en the lowliest of the earth may feel
  The blessed service of a life so given
As that of him, whose name we write in tears,—
  Whose days, well spent ,find all fulfilled in Heaven.

Dr. Richard Hughes, formerly of Brighton, was born in London, England, in 1836. He was educated in London, receiving the title of M. R. C. S. of England ,in 1857, and of L. R. C. P. of Edinburgh, in 1860. The title of M. D. was conferred upon him by American colleges a few years later. Dr. Hughes settled in Brighton, England, and remained there until within a year of his death, when he went to the little town of Albany, Guildford, to become the pastor of a Catholic Apostolic Church, of which he was an active member for many years.

Dr. Hughes was elected a member of the British Homœopathic Society in 1861. In 1862 he read his first paper before the society. It was entitled "On the Indications Afforded by Physiology and Pathology for the Selection of Homœopathic Medicines, and on the Need o fa Scientific Pathogenesy and the Means for Its Attainment."

His first work, "*Manual of Pharmacodynamics,*" was published in 1867, and was followed soon after by his "Manual of Therapeutics." About this time he became one of the editors of the British Journal of Homœopathy, and contributed many papers to its pages. After 1872 his contributions were less regular. He had the position of Secretary of the British Homœopathic Society in 1879; was its Vice-President in 1885-6, and Preesident in 1887.

The *Cyclopædia of Drug Pathogenesy,* published by that society, was principally edited by Dr. Hughes, and many of its pages were his work exclusively.

At the reorganization of the British Homœopathic Society in 1892, he was appointed editor of its *Journal,* and continued in that capacity until his decease.

The "*Summary of Pharmacodynamics and Therapeutics,*" published as an addendum to the Proceedings of the Society, was entirely the fruit of his toil.

In 1876 Dr. Hughes aided in the organization of the *International Congress of Homœopathic Physicians* in Philadelphia, and was appointed its Permanent Secretary. He attended two of its meetings in this country. In 1884 he delivered a special course of lectures in Boston University School of Medicine, which were afterward published under the title, "Knowledge of a Physician." He was elected honorary member of the Massachusetts Homœopathic Medical Society.

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Dr. Hughes was President of the International Congress held in London in 1881, when he delivered an oration on "Hahnemann as a Medical Philosopher."

He wrote a great number of valuable articles for the numerous homœopathic societies and journal, and wrote as he spoke—always courteously, clearly and convincingly.

Dr. Hughes' mortal body was committed to the grave on Thursday, the 10th of April, at his peaceful, retired home at Albury, near Guildford. The day was brilliant, well befitting the end of such a consistent Christian life, and of a noble devotion to duty. BUSHROD W. JAMES.

MRS. EMILY FAIRBANKS TALBOT

BOSTON, MASS

Mrs. Talbot was elected an honorary associate member of the Institute at the meeting held in Saratoga in 1887. She was born Feb. 22, 1834, in Winthrop, Maine. With the spirit which pervades New England, and which has given to America so many brilliant men and women, she early imbibed a love of knowledge and was given a thorough mental training. She was engaged in teaching in the city of Baltimore in 1854. It so happened that Dr. I. Tisdale Talbot came to Baltimore about this time on a visit to his sister, Mrs. Richards, before his departure to Europe to continue his medical studies. Here he met Miss Fairbanks, and on his return from Europe, he claimed her as his bride. They were married Oct. 29, 1856. The young people made a prolonged stay in Europe, finding much that was congenial in the old trodden paths, and ever keeping in view the acquirement of useful knowledge along chosen lines.

Returning to their native land, they settled in Boston, there to inaugurate the great work which together they were to accomplish.

The first public work for the cause of homœopathy, and humanity as well, that engaged the attention of Mrs. Talbot was in connection with the fair held in 1859 for the Boston Homœopathic Medical Dispensary. From this on, in spite of the cares incident to a large family, she actively co-operated with her husband during the succeeding years in his labors as editor of the New England Medical Gazette and General Secretary of the American Institute of Homœopathy during the critical time of its re-organization. Later the organization of the Massachusetts Homœopathic Hospital led to various successful efforts to secure means and friends for its support, and from this time forward she took an active part in the many enterprises undertaken in its behalf.

A member of the first Board of Trustees of the Westborough Insane Hospital, she gave earnest attention to shaping the plans and policy of the institution, her large experience and well balanced judgment making her a most valuable officer of the hospital to the end of her useful life.

In the year 1887, Mrs. Talbot was elected an honorary associate member of the American Institute, in appreciation of the services she had rendered to the Institute and the cause of homœopathy. She was the organizer and first president of the Meissen Society, which has proven so valuable an adjunct to the American Institute. Nor did her initiative and organizing power stop

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there; she was mainly instrumental in adding to the Massachusetts Homœopathic Hospital the Maternity, also in founding the Boston Latin School for Girls, the Collegiate Alumnæ, the well known association of literati, the Round Table Club of Boston. She was actively interested in and a director of the Massachusetts Infant Asylum, and as secretary of the educational department of the American Social Science Association she consulted with the famous scientist, Charles Darwin, and gave the first real impetus to child study in a systematic way in America.

Such in brief outline was Mrs. Emily Talbot and her work. It is the record of a life devoted to the good of her kind; it indicates the wonderful resources of a splendid intellectual endowment governed by impulses thoroughly good. It indicates a power of initiation with a remarkable degree of executive force in reserve by which great plans are conducted to continued development and success.

A. C. C.

FRANCIS E. BOERICKE, M. D.

PHILADELPHIA

Dr. Francis E. Boericke became a member of the Institute in 1865.

Dr. Boericke was born in Glauchau, Saxony, Germany, on June 18th, 1826. Young Boericke received a good education, and after the political reaction which followed the revolutionary movement of 1848, he became dissatisfied with the prospects in Germany and in 1849 he emigrated to America and settled in Philadelphia.

In 1853 Francis E. Boericke and Dr. Rudolph L. Tafel, trading as Boericke & Tafel, opened a store for the sale of books, in connection with which, and with the co-operation of their friend, Dr. Constantine Hering, they opened a department for the sale of Homœopathic medicines. Dr. Rudolph L. Tafel withdrew from the firm at the end of the same year, 1853, about six months after, and the business was then carried on by Mr. Boericke alone. The Homœopathic part of the business grew from year to year and promised a good field for all of Mr. Boericke's enterprise. In order to improve himself in his use as a Homœopathic pharmacist he took a course in the Hahnemann Medical College of Philadelphia, from which institution he was graduated as a Doctor of Medicine in 1857.

In 1868 he purchased the pharmacy of Dr. Boone in Baltimore, and in 1869 that of Mr. Wm. Raddle in New York. After this, also in the year 1869, he associated himself with Mr. Adolph J. Tafel, under the well known firm name of "Boericke & Tafel." Together with Mr. Tafel he established himself further in San Francisco, Chicago, Pittsburg and New Orleans. Dr. Boericke retired from the pharmacy business on January 1st, 1883, and devoted himself entirely to the publication of Homœopathic literature, styling his business "The Hahnemann Publishing House." This business he further developed to a considerable extent and sold the same to Boericke & Tafel in 1891. He died after many years of patient suffering, on the 17th of December, 1901.

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ALONZO BOOTHBY, M. D.

BOSTON, MASS.

On Saturday, February 9th, 1902, Dr. Boothby, one of the most distinguished surgeons of our school, died in Boston, at his residence, 508 Commonwealth avenue. He had selected surgery, and especially gynecology, as his specialty, and he filled the positions to which he was elected and which he undertook with credit and ability, being a thoroughly educated physician, and having added thereto a special study of the branch which he had selected, having visited all the larger hospitals of Europe, and having taken special courses at Berlin, Vienna and London. He soon felt himself competent, on his return, to establish himself in this department in the city of his choice, becoming one of the visiting surgeons of the staff of the Massachusetts Homœopathic Hospital, and subsequently being elected consulting surgeon thereto in 1894, and served as such until 1896. He also became president of the Surgical and Gynecological Society of Boston, and the local medical society of Boston at one time elected him its presiding officer. He was one of the original members of the faculty of the Boston University School of Medicine, and was the demonstrator of anatomy and professor of surgical anatomy and minor surgery, and likewise associate professor of surgery and surgical diagnosis, and at the time of his death held the chair of gynecology in that institution. He had also established a surgical institution for the care and treatment of this class of patients, and likewise connected therewith a school for nurses.

Dr. Boothby was born at Athens, Maine, in 1840, beginning his study of medicine with Dr. Kinsman at the early age of nineteen. He took a two years' course in Brunswick, going to New York in 1861 and taking there a supplementary course. After he had graduated at the Georgetown Medical College he became an army surgeon, Dr. Bliss assigning him to duty in the army of the Potomac during the late Civil War. He did four weeks of hard surgical work after the Battle of Gettysburg, among the wounded at the front. Subsequently he became the first assistant surgeon of the 2nd U. S. Colored Regiment, and so great was the animosity of the enemies of the government that an angry mob attacked them, and he narrowly escaped with his life in the streets of New York in 1863. He was subsequently sent to Key West while the yellow-fever was raging there, and was obliged to obtain a furlough and return North. Subsequently he found that the duties of his position were so arduous that he was obliged to resign. He went to New York and thence to Maine, where an attack of yellow-fever developed and he nearly lost his life from that dreadful disease.

He went to Wilton, Maine, in 1865, remaining there for a couple of years, when he removed to Boston. He took up the study of homœopathy there and after a proper course of study began its practice, and maintained his belief in its doctrines until the day of his death. He had a large general practice, but in 1883 he made this trip to Europe, where he obtained the best methods of operating, having obtained already a very excellent knowledge of the branch of his choice. In 1887 he took another three months' visit to Europe among the hospitals, and while his patients thought that he was having recreation and rest he was devoting himself to the practical study of his chosen branch.

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BOWMAN H. SHIVERS

FRANCIS E. BOERICKE

HENRY CLARK HOUGHTON

FINDLEY EDGAR DOWNEY

CHARLES ELLIOTT PINKHAM

ALONZO BOOTHBY

SARAH W. ANDREWS

SARAH SMITH

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He gradually gave up the large general practice which he had gathered together, and assumed the duties of a surgeon, obtaining a very prominent position in that branch of study and in gynecology. He was not only prominent in his profession, but he enjoyed quite a distinction among the Masonic Fraternity, as well as that of Odd-Fellowship. He was buried from his residence on February 12th, and the funeral was attended by a large number of his friends, medical associates and admirers.

He was a man which the profession honored and respected for his ability and the great amount of arduous labor which he performed in the line of his favored specialty. He was of a nervous temperament, and yet a most genial, active, intelligent and highly esteemed and most worthy member of the medical and surgical profession. The Institute mourns his loss deeply, for he had done much in the way of preparing papers and taking part in the discussions of the topics of the section of the department of medicine with which he was connected. He was always at his post, and the articles which he wrote and the experience which he gave in debate were of the most instructive character.

Greatly do we mourn his loss and we sympathize with his widow and his son in their great bereavement. He was loved by all the members of the profession who knew him, and the estimable character which he bore and the prominence which he obtained in his profession indicate how heartfelt and deep was the regard for him, and how great the sympathy of all who knew him, which the medical profession extends to the bereaved ones.

B. W. J.

JOHN C. BURGHER, M. D.

PITTSBURG, PA.

Dr. Burgher became a member of the Institute in 1854.

Dr. Burgher was a native of Ohio, born in 1822. He graduated at the Classical Academy of Windham. His preceptor in medicine was Dr. D. M. Dake. He became a student in the office of Dr. J. P. Dake in 1851. He graduated in medicine from the Homœopathic Medical College of Pennsylvania in 1854. Dr. Burgher was one of the organizers of the Homœopathic Medical Society of Allegheny County, and was elected its first president. To this office he was repeatedly re-elected. Dr. Burgher was active in aiming to establish the Pittsburg Homœopathic Hospital and Dispensary. He was a member of the American Institute of Homœopathy for forty-seven years, and served as secretary of that body from 1880 to 1887. In 1878 he was president of the Institute.

Dr. Burgher was a man of simple tastes, and of a courtesy which came of goodness of heart. He died at Pittsburg, Pa., August 11, 1901.

CLIFTON FRENCH HAYES, M. D.

SAN FRANCISCO.

Dr. Hayes became a member of the Institute in 1875.

Dr. Hayes was born in Leicester, England, May 21, 1840. His father emigrated to America in 1847, and with his little family of two sons and a daughter, settled in Lorain County, Ohio.

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Dr. Hayes began the study of medicine with Dr. Jamin Strong, of Elyria, Ohio, who was then, and for many years remained, Professor of "Materia Medica" in the then new "Charity Hospital College" of Cleveland, Ohio. In the winter of 1859 he entered "Ann Arbor University," and finished his first course of Medical lectures that winter.

In the spring of 1861 he formed a partnership with Dr. Swift, of Northville, Mich., with whom he remained till the first call came for volunteers to defend the Union, when he enlisted in the "17th Michigan Volunteer Infantry," serving through many of the principal battles of the rebellion. During the long marches through the swamps of the South-land he contracted rheumatic fever and was sent to the Army Hospital at Baltimore, Md., where he was very ill for three months, and upon recovery served as "Assistant Surgeon" and "Hospital Steward," and was honorably discharged for disability.

In 1864 he returned again to Ann Arbor, and completed his course, and in April, 1865, graduated from the Medical Department of the "University of Michigan." After several years spent in the practice of medicine according to the tenets of the "Regular" school, and taking several lecturing tours, he settled in Chicago, and in 1870 he helped to organize and establish the "Bennett Eclectic Medical College" of Chicago, Ill. Here he remained for two years, filling the chair of Professor of "Physiology and Hygiene," until excessive labor produced loss of voice and he was compelled, reluctantly, to resign his chair in the college.

For several years Dr. Hayes served on the Board of "State Medical Examiners," also as Editor of the "Eye and Ear Department" of the "California Homœopath," has also written many articles for the Homœopathic journals throughout the country; also for the "North American Review," the "Review of Reviews," and had in preparation at the time he was stricken with paralysis, three years ago, several text-books on his specialty, which, from his twenty-one years' practice, must surely have been of value to the profession.

To those who knew Dr. Hayes intimately, no word need be said of his generous, large-hearted kindness of disposition, or the uprightness of his charactor, and while it was impossible for one of his positive, dominant nature to go through the world without making some enemies, still those not agreeing with him in all things will admit his integrity of purpose and his love of humanity.

And among the poor and needy he will long be remembered.

Among the poems worthy to live are several written in honor and praise of the cause of Homœopathy and its grand founder, Hahnemann.

GUSTAVUS EDWARD GRAMM, M. D.

ARDMORE, PA.

Dr. Gramm became a member of the Institute in 1869.

Gustavus Edward Gramm, M. D., died on Saturday, November 2, 1901, at the house of his son, Dr. Theodore J. Gramm, in Philadelphia. He was buried in West Laurel Hill Cemetery.

Gustavus E. Gramm, the son of Christian Gottlieb Gramm and Mariana von Walwitz, was born near Halle, Germany, on November 18, 1823.

After receiving a thorough classical education at Halle, he spent thirteen

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years as private tutor in families of the German and Austrian nobility. In 1856 he visited America for the purpose of travel, and while being entertained in Baltimore, at the house of a famous minister of the Reformed Church, he was induced to remain in this country, and also to prepare for the ministry, in which he spent several years of arduous labor, the duties of which charge induced serious ill health. He was thus brought into contact with Dr. Constantine Hering, whom he consulted, and under whose care his health was restored. Some time thereafter he began the study of medicine, primarily for the sole purpose of philanthropic work among the poor in his neighborhood. He graduated in 1867 from the Homœopathic Medical College of Pennsylvania, which was afterward merged into the Hahnemann Medical College of Philadelphia. He ultimately adopted the practice of medicine as a profession, and now began another period of earnest work, for, as the pioneer of the Homœopathic method in Kensington, he soon acquired an extensive practice, and became widely known as a successful physician. In 1884 his health, failing again, compelled a temporary retirement from active work, after which he spent the remaining years of his life (except the last year) at Ardmore, Pa., where he continued the practice of his profession.

Dr. G. E. Gramm's friends and associates for many years were the old coterie of illustrious medical men whose names are so intimately connected with the history of homœopathy in America, namely, Hering, Guernsey, Lippe, Raue, Felger, Koch and others. His frequent contact with these men had, doubtless, a potent influence in determining his point of view of homœopathic medical practice, for he was ardently devoted to the study of the materia medica, and to this, his favorite branch of medicine, he applied himself with unwonted zeal. He was a thorough believer in the value of the materia medica, and often recorded the results of his studies and of his experience in manuscripts of mucn value. Indeed, for a number of years past, and until within a few weeks of his death, although suffering constant pain, he was engaged with surprising diligence upon an extensive repertorial work of the materia medica. He also contributed to the current medical literature of his earlier time, and made a number of translations from the German. He was a senior member of the American Institute of Homœopathy and of the Pennsylvania State Society, and was connected with the county society and other local clubs. Dr. Gramm was also a member of Meridian Sun Lodge, No. 158, Free and Accepted Masons, and of Oriental Chapter, No. 183, Royal Arch Masons.

The first half of Dr. G. E. Gramm's life was devoted to educational and philanthropic work, and he labored with unrestrained energy. During this time he developed that innate refinement which so distinctly characterized him in all the activities of his later years. He had also learned to look upon the duties of life from a not altogether common point of view, for he was distinguished by an ever-present conscientiousness in his work which kept him free from sordid motives, though it sometimes militated against his merely pecuniary advantages as a business man. His motives were ever noble, and his ideals always exalted. In the care of a patient nothing restrained his earnest endeavors, and to be able to observe a recovery from disease through his instrumentality was his dearest recompense. Indeed, he never regarded the practice of medicine as a pecuniary undertaking, but looked upon it as a sacred trust in the discharge of which he was at all times willing to expend his utmost strength. He was by nature genial, cordial and sincere, and his man-

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ner toward others was always marked by a well-bred politeness which was just a bit un-American. He was endowed with a happy, sanguine temperament. He was a passionate lover of music, and in former years often reveled in the productions of his favorite composers. In more serious employments he was conscientious and self-sacrificing to a fault. He would not compromise his self-respect, and was ever mindful to retain the commendations of his own conscience. He was true to his sense of right, irrespective of consequence. He was a Christian gentleman!

Dr. G. E. Gramm's wife died one year prior to his decease. Two sons survive him, Dr. Edward M. Gramm and Dr. Theodore J. Gramm, who are both in special practice in Philadelphia.

JOHN R. HAYNES, M. D.

INDIANAPOLIS, IND.

Dr. Haynes united with the Institute during its session at Cincinnati in 1865.

Dr. Haynes was born in Otsego County, N. Y., March 13, 1823, was reared in his native county, remaining upon the farm and attending school until he was seventeen years old, at Otsego, when he entered the New York City University, from which he graduated in the classical and scientific course in the year 1844. Three years later he began the study of medicine at New York City and took two courses of lectures at the University of New York and finally graduated from the Eclectic Medical Institute at Cincinnati in 1849. He then located at Newport, N. Y., where he carried on a general practice for about twelve years. In the year 1863 he came to Indianapolis and has followed the practice of his profession ever since. He was one of the originators of the Indiana Institute of Homœopathy, having been treasurer of the latter for fifteen years. Dr. Haynes was married in 1847 to Miss Mary E. Ladd, a native of Pennsylvania, who had removed four years previously to Kentucky with her parents. He was one of the originators of the International Hahnemann Association. Dr. Haynes was noted as an exceptionally excellent prescriber and was a most faithful adherent to the law of similars. He died March 10, 1902.

HENRY CLARK HOUGHTON, M. D.

NEW YORK

Dr. Houghton became a member of the Institute in 1867.

Henry C. Houghton was born in Boston, Mass., January 22, 1837. He graduated at the Bridgeport Normal School in 1859. He graduated in medicine at the New York University in 1867. He was professor of physiology in the New York Homœopathic College from 1868 to 1870, after which time he was professor of otology in the same institution to the time of his death. He was also surgeon to the New York Ophthalmic Hospital. He was author of "Lectures on Clinical Otology."

Descended from a line of pious ancestors, Dr. Houghton's capacity for religion was exceptional, and his supreme delight was in the contemplation of

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the things which are unseen and eternal. Religion to him was not a thing apart, it was his whole existence. He loved the church of God with all his heart. To work for it and for every cause in which Christ's life found some new embodiment was life and peace and joy. He was indeed a Christian gentleman. His nature was peculiarly sensitive and affectionate, and by the subtle power of a winsome personality he made for himself a place in the hearts of those whose lives he touched. In all his dealings and relationships he was a man of honor and integrity. Gentle, quiet, gracious, loving, he moved among his friends so long and so unostentatiously that they knew not how large a place he filled. He was a man of many gifts and graces. His influence had inspiration in it. He filled many spheres of usefulness and added charm and strength to many a circle. He was wondrously generous and sympathetic, how gracious only those can know to whom he ministered for no regard other than that which the Master gives. Into various institutions his presence carried light and healing, and his death brought deepest sorrow to those who knew him best.

Dr. Houghton died at his home in New York December 1, 1901.

The Homœopathic Medical Society of the County of New York passed the following memorial resolutions:

WHEREAS, Dr. Henry C. Houghton, one of the oldest members of this society, by his wise counsels, his upright character, and devotion to professional and especially homœopathic interests, did much toward the upbuilding of this society and the advancement of the special department of otology, and by his well ordered and useful life did exemplify the true physician and Christian, and,

WHEREAS, In the order of Divine Providence an honored and beloved member of this society has been removed by sudden death; therefore,

Resolved, That the demise of our esteemed associate comes to each of us as a personal bereavement.

Resolved, That with those more immediately smitten by this great affliction we share the grief of an irreparable loss.

Resolved, That as a society and as individual members, we extend to the bereaved family our deepest sympathies in this their hour of sorrow.

F. E. DOUGHTY,
WM. TOD HELMUTH,
I. McE. WETMORE,
Committee.

ELIAS C. PRICE, M.D.

BALTIMORE

Dr. Price united with the Institute during its session in New York City in 1867.

Dr. Price was born in Baltimore Co., Maryland, April 16, 1826, in his father's house, located on the old Price tract granted to his ancestors in 1733 by the English crown. His education was obtained in the common schools of his neighborhood, supplemented by much independent study later in life, which put him abreast with many whose early advantages had been far greater. After teaching school for a year he entered the medical department of the

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University of Maryland, where he graduated in 1848. He at once entered into partnership with his preceptor, Dr. Madlen Price, of Baltimore County.

Within five years of this time he gave his attention to the study of homœopathy and became the pioneer homœopathic practitioner of Baltimore County. His field of practice gradually extended until it reached over the line into Pennsylvania and into the city of Baltimore. In April, 1865, he removed to Baltimore and was soon engaged in a large and lucrative practice, being in a short time considered one of the leading practitioners of his school.

Dr. Price was one of the organizers (Sept. 2, 1874) of the Baltimore Homœopathic Medical Society (the first homœopathic organization in the state), was elected its first president, declined a second term the following year and was again elected to fill that office in 1877. He was one of the organizers of the Maryland State Homœopathic Medical Society and was elected its first president. He was one of the incorporators of the Homœopathic Free Dispensary of Baltimore. For over two years he was obstetrical editor of the American Observer, published in Detroit, Mich. He was one of the incorporators of the Southern Homœopathic Medical College and Hospital (1890) and for the first eight years of its existence was professor of institutes of medicine and hygiene in the institution. In 1892 this college conferred upon him the honorary degree of doctor of medicine. He was a member of the Southern Medical Association. Besides discharging the duties of a large practice, he wrote much for the medical magazines of the country, and was the first to teach the use of various drugs and procedures for the use of the sick. In addition to his lucrative practice, probably no physician in Baltimore gratuitously tendered greater amount of services to the poor. Not only did he give his services, but many times the wants of the poor were supplied from his own pocket.

Dr. Price was a member of the Society of Friends. He was married in 1852 to Miss Martha Cowman, daughter of John P. Cowman of Alexandria, Va. Dr. Price died June 16, 1902.

SARAH W. ANDREWS, M.D.

CHICAGO

Dr. Andrews became a member of the Institute in 1890.

Dr. Andrews was born in La Porte, Ind., and her mother was a prominent Quaker preacher. When she was married to George H. Andrews in 1851, she was excommunicated by the Quakers, and soon after her marriage became a Baptist from conviction.

Although Dr. Andrews was not graduated from a medical school until 1882 (Hahnemann), she had shown a natural fondness for medical studies from her earliest years. Dr. Andrews, as a physician, always brought to her patients, in addition to her medical skill, a peculiar personal interest and devotion. She was a student to the end of her life, spending a winter in Vienna in special study only three years ago.

Dr. Andrews was a woman of great force of character, with clear vision of that which she desired to accomplish and untiring persistence in the

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accomplishment of the ends sought. She loved to be helpful. Ministry was her delight.

Dr. Andrews died at her home in Chicago, February 26, 1902.

CHARLES LEWIS BONNELL, M.D.

BROOKLYN, N. Y.

Charles Lewis Bonnell, M. D., was born in Brooklyn, October 15, 1846. His father, Nathaniel Bonnell, who died in 1873, came to Brooklyn in 1827, though the family, which was Flemish, settled in New Jersey. Dr. Bonnell received his academic education in Brooklyn, and then entered Wesleyan University, from which he graduated and received the degree of A. B., with the class of '68. In 1871 he received the degree of A. M. from his alma mater. He obtained his M. D. from the Hahnemann Medical College in Philadelphia in 1871, after two years' preliminary study in the College of Physicians and Surgeons in New York, and began practice in 1872.

Dr. Bonnell was President of the Kings County Homœopathic Medical Society two terms. During most of that time he has acted as Visiting Surgeon, and for the last six years was Chief of Staff. He was six years on the Staff of the Brooklyn Maternity, and was a lecturer there and at the Homœopathic Hospital for several years. He was consulting Surgeon to the Memorial Hospital for Women and Children. He was a member of the New York State Homœopathic Medical Society, and has been a Director for twelve years of the Brooklyn Young Men's Christian Association. In 1872 he married Miss Elizabeth W. Irvine, of Brooklyn.

Dr. Bonnell died January 15th, 1902.

FINDLEY EDGAR DOWNEY, M.D.

CLINTON, ILL.

Dr. Downey became a member of the Institute in 1882 at Indianapolis.

Findley Edgar Downey was born in Atlanta, Ill., January 6, 1859, and died one day before what would have been his forty-third birthday.

After graduating from the Atlanta High School, he entered Rush Medical College, Chicago, in 1877, and later the Pulte Medical College, Cincinnati, from which he graduated in 1879, when 20 years old, and soon after located in Clinton, which had since been his home. July 29, 1880, he and Elvira Hutchin Lane were joined in marriage in Clinton.

He was recognized as one of the leading Homœopathic physicians of Illinois. He was several times elected treasurer of the State Homœopathic Association, and less than a year ago was made its president. He attended lectures in Chicago and other cities, keeping well abreast of the advancement in medicine and surgery. The only official position he held in Clinton was president of the school board, having been elected five times successively, and his term would have expired next April. He had been a member of the Presbyterian church several years, and was ever active in church work. He was one of the present official board, being trustee, and had often held other church offices. Politically he was a Republican, though he seldom took an active

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part in political matters. He was a Mason, being a member of Goodbrake chapter, R. A. M.

While Dr. Downey had an extensive practice, his ambition was to become noted in his profession rather than wealthy. His chief ambition is said to have been to become a surgeon among the best in the state and was striving to have that desire realized to the fullest extent. At the meridian of life he had a practice that few of his age enjoy, and his home was among the best in the city.

The following resolutions were passed by the Board of Education:

WHEREAS, Death has claimed one of our number, Dr. F. E. Downey, President of the Board of Education of District 8; therefore be it

Resolved, That we, the members of the Board of Education, realize the severe loss sustained by the public schools of our city. In him, we had a wise counselor, ever bending his energies toward that which conscience indicated to him to be right, and for the advancement of the schol's interests. We recognize in his death not only the loss of a most efficient and wise executive who fearlessly performed the obligations of his office, but of one whose death is to be deplored by this city because of his energy and earnestness in her welfare.

Resolved, That our fullest sympathy be extended to the wife and family in their bereavement; that a copy of these resolutions be sent to the family, be published in the city papers, and be spread upon our records.

F. J. Crang, *President pro tem,* A. J. Latimer, *Secretary,* A. E. Shell, F. R. Kent, J. H. Schmith, C. F. Crum.

EDWARD A. FISHER, M.D.

BUFFALO, N. Y.

Dr. Fisher became a member of the Institute in 1897.

Dr. Fisher was one of the active members of the staff of the Buffalo Homœopathic Hospital. One of the physicians pays this high tribute to him: "All of us held him in high regard, and those who knew him well loved him for his genial spirit and honest heart." His place in the staff will be hard to fill. Four times within the past ten months we have seen our earnest workers lay aside the burdens of life for eternal rest and each blow seems harder to bear. We offer his family the sympathy of loving, sorrowful hearts. The funeral on March 4th, under the charge of the Masons, was attended by a large number of medical men.

Dr. Fisher died March 1st, 1902, aged 42 years.

At a special meeting of the staff of the Buffalo Homœopathic Hospital, held at the Hospital parlors, on Sunday evening, March 2nd, 1902, Dr. John A. Miller, presiding, the following resolutions were adopted:

WHEREAS; In the dispensation of Providence, Dr. E. A. Fisher has been called from co-operation with us on this staff, and

WHEREAS; We, feeling deeply the loss of one who has for several years been not only an active, earnest, co-worker, but a genial friend; always kind and ready, both in hospital and private work; therefore,

Resolved, That we hereby express our sense of bereavement in the loss we have suffered, and our sincere mourning, by th adoption of these resolutions. Also,

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Resolved, That our deepest sympathy be expressed to his family, with whom we feel that we have sustained a personal loss; and that these resolutions be recorded in the minutes of this Staff and a copy of them sent to the family. Also,

Resolved, That we, as a Staff, attend the funeral in a body. Signed,

E. P. Hussey, M. D., H. C. Frost, M. D., B. J. Maycock, M. D., Committee.

JULIA GOODMAN, M.D.

HAMILTON, O.

Dr. Goodman became a member of the institute in 1892.

Dr. Julia Goodman is a daughter of Henry Mergenthaler. She was born July 20, 1848. When quite young she was married to C. B. Goodman.

The happy married life of Mr. and Mrs. Goodman was ended by the death of Mr. Goodman. This changed the plans in life of Mrs. Goodman. She studied medicine and graduated in 1884 at the New York Medical College for Women. Dr. Goodman died June 6, 1902.

FRANK R. SCHMUCKER, M.D.

READING, PA.

Dr. Schmucker became a member of the Institute in 1892.

Dr. Schmucker was one of the best known and oldest homœopathic practitioners in Reading.

Dr. Schmucker was born in this country and was in the 64th year of his age. After attending schools in this section he graduated from Yale College in 1860 and in 1862 began the study of law.

At the outbreak of the Civil War he enlisted and was made first lieutenant of Company A, 128th Regiment Pennsylvania Volunteers. After serving nine months he returned to Reading, and on February 8, 1863, he re-enlisted and was made captain of Company C, 42d Regiment. Later he held the office of adjutant.

In 1873 he graduated from the New York Homœopathic College, and in 1874 began to practice in Reading, continuing here until his recent illness. He was a contributor to medical journals in this country and in Europe.

He was a wise and able physician and beloved by all with whom he came in contact. He was held in high esteem both by the profession and laity. Dr. Schmucker was a member of the First Presbyterian Church for nearly forty years and for many years was a ruling elder of the congregation. He is survived by his widow and five sons.

JESSIE SHEPARD, M.D.

BUFFALO

Dr. Jessie Shepard, of Buffalo, N. Y., the granddaughter of a physician, was born in Buffalo, in the year 1861. She received her early education in one of the district public schools, and in the Central High School. Choosing the profession of a physician, she began her medical studies in the office of

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the late Dr. A. C. Hoxsie. She attended one year the Homœopathic Hospital College in Cleveland, Ohio, and later the Boston University, medical department, where she was graduated in 1888. She served one year as house surgeon in the Massachusetts Homœopathic Hospital, and for some time afterward practiced in the office of Dr. Joseph T. Cook, of Buffalo, N. Y. Some few year ago she went to Vienna, Austria, and spent a year in the General Hospital there, afterwards returning to Buffalo to continue her work.

Dr. Shepard's death on August 24, 1901, following an operation for appendicitis, was a great shock to a large number of friends. Possessing ability, industry and fondness for her work, she had also much sympathy and tenderness, and was a woman that endeared herself to those who came in contact with her.

The professional associates of Dr. Jessie Shepard learned with most profound regret of her sudden and untimely death. Dr. Shepard was one whom to know was to admire, and the closer the acquaintance, the deeper the respect and admiration engendered by her quiet and unostentatious manner, her cordial good fellowship and her genuine ability. Strong, without losing her womanly tenderness, active and energetic, without being aggressive, she inspired with confidence and esteem all with whom she came in contact in her professional as well as her personal relations of life. The question of physical weariness or tax on her strength never prevented her responding with cheerful alacrity to any call for her professional aid, whether that call was from the homes of her more wealthy and influential patrons, or from some poor sufferer from whom the only recompense to be looked for was the thankful recognition of her ability and assistance. The conscientious thoroughness and the careful skill with which she accomplished any duty demanding her attention were among her more marked characteristics.

Dr. Shepard ever strove to keep entirely abreast of the times in all that pertained to the scientific and most advanced branches of her work. She was a close and intelligent student, possessing also the tact and ability to utilize to the fullest extent the results of her study and investigation.

Her associates in the hospital, in the home and in medical societies will miss her hearty co-operation, her ready but always kindly criticism, and her valuable aid in lines in which her personality made her particularly efficient, and where her loss will be most deeply felt.

Dr. Shepard for some years held an appointment as an obstetrician upon the staff of the Buffalo Homœopathic Hospital, where she had performed most excellent and painstaking work. She had recently been chosen, after much consideration, to serve upon the medical committee in charge of the Training School for Nurses, attached to the same hospital. This latter appointment was a great compliment to her and a special evidence of the high position she had made for herself in the city and among the physicians of the hospital staff.

She was a member of Erie County, the Western New York, and the New York State Homœopathic Medical Societies, and was deeply interested in their work, as well as that of the American Institute of Homœopathy.

JOS. T. COOK.

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SARAH SMITH, M. D.

COUNCIL BLUFFS, IA.

Dr. Sarah Smith was born near Joliet, Ill., and lived during childhood upon a farm. Her first years at school were spent in the proverbial "red school-house," but later she entered the public schools of Aurora, Ill., graduating from the High School in the class of 1872. She taught in the city schools of Aurora for eleven years with marked success. Coming west in 1883 she soon took up the study of medicine in the office of Dr. A. P. Hanchett of Council Bluffs, Ia., graduating from the Hahnemann Medical College of Chicago in February, 1887. She returned to Council Bluffs after securing her medical degree and entered into partnership with Dr. Hanchett, and very soon made for herself a reputation as a physician of much more than average ability that extended far beyond the confidence of her own city. She took a course in the Post-Graduate School of Homœopathics of Philadelphia in 1892.

Dr. Smith was on the homœopathic staff of the Woman's Christian Association Hospital of Council Bluffs and one of the lecturers to the nurses in the training school of this hospital.

She died after a lingering illness of eight months, of organic heart disease, Dec. 22, 1901, at the home of Dr. A. P. Hanchett. A.P. H.

WM. VON GOTTSCHALCK, M.D.

CENTRAL FALLS, CONN.

Dr. Von Gottschalck became a member of the Institute in 1885.

Few of the older members of the Institute will fail to recall the genial manners and the whole-souled devotion to homœopathy that characterized the gentleman bearing the above name who served us five times as the chairman of the bureau of anatomy and physiology, and was called to his final rest in 1888. (See Transactions of 1889.) He left at that time a son already established in his own vocation to perpetuate his name in the state and in the societies with which himself had long been identified. The latter was born in 1855 at New York city, but the family removed in 1856 to Providence, R. I. There the youth fully availed himself of the benefits of the public schools. Early manifesting an aptitude for his father's profession he was sent to the Boston University School of Medicine, where he was graduated in 1877. That very year he opened an office in what was then the village of Central Falls in the town of Lincoln, R. I., and there he maintained a home so long as life continued. Though his father was a staunch Republican, he himself was a pronounced Deomcrat, and as such was sent by his town to the lower branch of the legislature in 1888, 1889 and 1890, during which years he was a member of the committee on the militia. When the village became a city Dr. Gottschalck was his party's first candidate for mayor, but he was defeated. In December of that same year he was elected to the office on a Democratic and a citizens' ticket by 48 majority. In 1896 he was chosen by a plurality of 335, though defeated the ensuing year in a heated contest by three votes. During the two years' administration of Hon. John W. Davis, the only Democratic governor that has guided the destinies of Rhode Island for many a year, he served on his personal staff with the rank of colonel. Prior to his settlement in life he had enrolled himself in the First Light Infantry Regiment

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of Providence, the elite military organization of the state. At the time of his death he was first lieutenant of Company E. He was also a member of the veteran association connected with that battalion. Formerly he had belonged to a number of secret societies, but at his demise was only in Superior Lodge, I. O. O. F., and Jenks Lodge, A. F. & A. M. He also was a member of the American Institute of Homœopathy (1885), the Rhode Island Homœopathic Society and the Pawtucket Medical Association, which selects its novitiates without regard to their tenets. In 1884 he married Miss Emma J. Whittle, of Saylesville, R. I., who, childless, survives him. He died April 3, 1902, of Bright's disease. The funeral occurred three days later at his residence. For several hours prior to the time designated for the service, a steady stream of people from all walks of life poured through the house to secure one last look at their physician and friend. Though there was no military display, his command attended *en masse*, and the Light Infantry Veteran Association in good numbers. Col. Frank W. Mattison, his regimental commander, and Brigadier-General Herbert S. Tanner were also present to pay their last tribute of respect. Among the elegant floral offerings was a shield from St. George's Parish (Episcopal) Church, and a design from the Central Falls Police. His remains were interred at Riverside Cemetery, Pawtucket, R. I.

GEO. B. PECK.

GROVE HERRICK WILSON, M.D.

MERIDEN, CONN.

Dr. Wilson was born at Stockbridge, Mass., March 25, 1824. His education was obtained in the district schools. He was graduated from the Berkshire Medical Institute in 1849. About two years later he began the study of homœopathy, and practiced it for nearly fifty years. He was always deeply interested in scientific investigations. He was a member of the Connecticut State Board of Health for eighteen years. He died at Meriden, Conn., January 10, 1902.

CHARLES ELLIOTT PINKHAM, M.D.

SACRAMENTO, CALIF.

Dr. Pinkham became a member of the Institute in 1901. Dr. Pinkham was born in New Brunswick, Maine, Dec. 16, 1839. He died at Sacramento, California, June 30, 1901. Dr. Pinkham served through the Civil War in the First Maine Cavalry, and two weeks previous to its close he was appointed captain of his company. He graduated from the Eclectic Medical College of Pennsylvania in 1868; afterward attended a course of lectures in Harvard Medical College. He was associated with Dr. Clapp in Boston. He settled in Woodland, Cal., in 1877. In 1880 he moved to Sacramento, Cal., where he was actively engaged in practice up to the hour of his death. He was appointed member of the Sacramento Board of Health in 1896, and was instrumental in the passage of the first anti-expectoration act on the Pacific Coast. He was honorary member of the *Phi Alpha Gamma Fraternity*, Alpha Chapter, N. Y. H. Med. Col., 1896. He was a thirty-third degree Mason; member of the Fair Oaks Post, Grand Army of the Republic, with rank of major. Dr. Pinkham's life was a long and useful one, and he died much regretted by many people.

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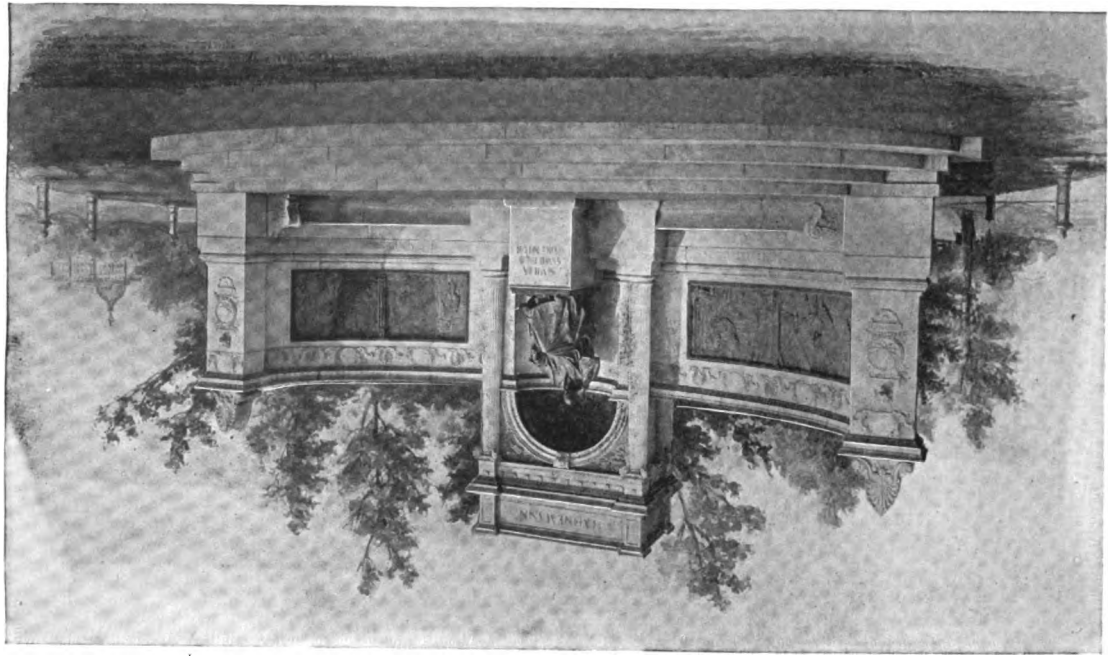

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